Post-Graduate Lecture
ON
RHEUMATISM,

Delivered at Charing-cross Hospital,

BY JULIUS POLLOCK, M.D., F.R.C.P.,
SENIOR PHYSICIAN TO THE HOSPITAL.

GENTLEMEN,—I am much honoured by having been requested to give the first of this course of lectures at Charing-cross Hospital. I feel at the same time that I have a great responsibility, for in an undertaking like the present a good start is all-important, and anxious as I am to to do my best, and with the keenest interest in the success of the course, my efforts may, and probably will, fall far short of my desire.

Before entering upon the special subject that I have been requested to treat, it is, I think, incumbent upon me to say a few words by way of introduction. There can be little reason to doubt the need of such a course of lectures as this, and the success of a similar plan of teaching in America, in Edinburgh, in Leeds, and in other places, has shown that under proper direction and favourable auspices such a mode of imparting instruction has met with the entire approval of those for whom the lectures are intended. We are, or ought to be, all of us students in the best sense of the word to the end of our lives; and with the vast amount of knowledge to be acquired, with the constant and important advances that are continually being made in pathology, the means of diagnosis, and the treatment of disease, it is quite impossible that the few years of study comprising the medical curriculum should suffice for the acquisition of a complete and final grasp of such vast subjects as medicine and surgery. Seeing, then, how great the advantages of a post-graduate course of lectures must be, it appears strange that such a scheme should not always have proved successful, but a little thought will show how important are certain details in the arrangement of the course, in order that it may meet the requirements of those for whom it is especially intended. A want of proper attention to such details has in some instances led to comparative failure. The lectures must be given at an hour when the busy practitioner is best able to attend. They must be essentially practical in character; and the subjects should be selected by those who desire to learn, rather than by those who are willing to teach. It is also desirable, in order to maintain the independence of the class, that the lectures should be self-supporting, and a moderate fee paid for the course. Another very important point is the hearty co-operation of the whole staff of a hospital in the work of instruction. It gives a higher tone to the task, a variety to the teaching, a lightness to the labour. Under conditions such as these there is every reason to hope that our post-graduate course of lectures may become popular and attractive, and obtain a permanent footing amongst the various means that exist for enlarging our knowledge and increasing our usefulness.

Let me now pass to the subject of my lecture. I have certain drawbacks to contend against to-day, which I do not allude to by way of complaint, but that you may know I have not overlooked them. In the first place, there is little or nothing new to tell you about rheumatism. No fresh light has been shed upon its pathology or treatment during the last few years, and I fear lest what I have to say to you may be "as tedious as a twice-told tale." Then, again, I am badly off in the matter of illustration. My subject is one that does not carry specimens or diagrams. Nor are we able at will to command the presence of a certain number of cases of rheumatic fever in the wards. At the present time there is but one, and he is convalescent. Such are my difficulties, and I am sure you will bear kindly with me. But to proceed. There are two forms of rheumatism, the articular and the muscular; and although they both are known under the common term "rheumatism," they are really, I believe, two separate and distinct disorders, with but little in common except their name. Articular rheumatism, as its name implies, is essentially an affection of the joints, very frequently associated with inflammation of the pericardium, endocardium, and other serous membranes, the structure of which so closely resembles the synovial. There is usually fever and marked constitutional disturbance. The disease, when uninfluenced by remedies, pursues a tolerably definite course, and has a strong tendency to wear itself out in time—say "six weeks," according to the first Dr. Warren. Its main features are those of an acute febrile attack, with local lesions. Muscular rheumatism, on the other hand, is a much more indefinite complaint, affecting the muscles, aponeuroses, and other fibrous structures, rarely accompanied by fever, never implicating the heart, and of very uncertain duration. Both these forms of rheumatism are full of interest, and will repay careful study; but either is a large subject, and it would be impossible to do justice to the two diseases in one lecture, so I propose, if you will allow me, to confine my attention this afternoon entirely to the articular form, which from its greater pathological importance may well claim precedence. This disorder occurs in three well-marked forms—the acute, the subacute, and the chronic. The first two are often spoken of as "rheumatic fever," and I shall not scruple to avail myself of this term to avoid tautology. Perhaps the subacute form, in which the temperature ranges from 99° to 102° F., is that most commonly seen, especially in hospital practice. It differs from the more acute variety simply in degree; all the symptoms are less severe, a fewer number of joints are implicated, and perhaps there is less chance of cardiac mischief. But it is quite as tedious as the acute form, and relapses are not uncommon. In chronic articular rheumatism there is generally no pyrexia, and I believe it is not unfrequently confounded with other kinds of joint disease. It is recognised without difficulty by the number of joints that are affected at the same time, and by the wonderful influence that salicylate of soda exercises over it. I call to mind one case of this chronic form, which came under my notice in the very early days of the salicylate of soda, and in which for nearly a month I tried every remedy for rheumatism that I could think of; at last I used the salicylate of soda and cured my patient in two days.

I propose to pass lightly over the ordinary phenomena of an attack of rheumatic fever, which are probably as familiar to most of you as they are to me; the symptoms of having "taken cold," the more or less pyrexia, the profuse and acrid sweat, the swollen, painful, and tender joints, the occasional metastasis, and the not infrequent implication of the heart, which latter complication, if it be a complication, and not, as some German authorities have held, the very essence of the disorder, are the more likely to occur in inverse ratio to the age of the patient. But there is a remarkable condition that sometimes arises during the course of an attack of articular rheumatism to which I desire especially to call your attention. I allude to what is known by the name of "hyperpyrexia." Now this state of high fever is not unknown in other diseases; it occasionally accompanies typhoid and scarlet fever; it is the very essence of *coup-de-soleil* or sunstroke, and is met with in various diseases of the nervous system; "but it is in connexion with acute rheumatism that it has attracted most attention and is most frequently encountered. Curiously enough, it is not only the more severe attacks of the disease that drift into hyperpyrexia; comparatively mild and subacute cases, which appear to be doing well, will now and then take this remarkable course. The symptoms of hyperpyrexia are very characteristic and well marked. The temperature, which in ordinary cases of rheumatic fever ranges from 100° to 103° F., or thereabouts, without any apparent reason begins to rise, and may ultimately attain the height of 110° or even more; at the same time the joint affection subsides, pain is no longer complained of, and the patient often expresses himself as better just as the most serious symptoms are coming on. In most cases, but not invariably, the profuse sweating ceases; the skin becomes dry, harsh, and intensely hot to the touch; very frequently a crop of sudamina breaks out upon the neck, chest, and abdomen (which latter symptom I have learned to look upon as a very unfavourable sign); the tongue becomes dry and brown; there is great thirst, with complete loss of appetite; the breathing is rapid, the pulse very quick and generally weak; the patient is tremulous and restless, with a suffused and 'ferrety' appearance about the eyes, delirious at night, but often fairly sensible in the daytime. The delirium is generally of a low, muttering kind, not unlike that of delirium tremens, though occasionally there is some excite-

ment. Unless the disease takes a favourable turn, or relief can speedily be given, death ensues in a day or two, apparently from mere hyperpyrexia."[1]

The occurrence of hyperpyrexia would appear to depend upon the nervous system being attacked by the rheumatic poison; at least this was the view that I took of it ten years ago, and which has since been abundantly confirmed. Dr. Maclagan says:[2] "Admitting the existence of a thermic centre, whose function it is to control heat formation and prevent undue rise of temperature, we have no difficulty in certain maladies and injuries in attributing the increased body heat to interference with that function. The temperature rises because the reins are slackened. The sequence of events seems to admit of no other explanation. Carrying out this line of argument, we cannot fail to see, not only that the rise of temperature thus induced must be directly as the extent to which heat inhibition is impaired, but that paralysis of the thermic centre, by abolishing inhibition and leaving heat production in uncontrolled possession of the field, must lead to hyperpyrexia. And the more we consider the pathogenesis of febrile heat, the more apparent does it become that impairment of inhibition is a much more likely cause of hyperpyrexia than is direct stimulation of heat production. Heat inhibition remaining unimpaired, tissue metabolism could scarcely cause those very high temperatures which characterise some cases of hyperpyrexia. Heat inhibition being paralysed, there is no difficulty in seeing that the temperature cannot fail to rise, and to go on rising, so long as tissue metabolism and heat production continue. All cases of hyperpyrexia we therefore regard as being probably of neurotic origin—as due to some cause which exercises a paralysing influence on the thermic centre. Pyrexia may result either from increased production or defective inhibition, but marked hyperpyrexia is probably due only to defective inhibition. In the cases hitherto instanced there has been a direct lesion of the nervous centres to explain the paralysis of the thermic centre and the consequent rise of temperature. Other cases there are, however, in which the evidence of paralysis of that centre is equally well marked, in which hyperpyrexia is pronounced, but in which the sequence of events by which it is brought about is not so apparent."

Now what is the etiology—what are the causes of rheumatic fever? These may, very properly I think, be divided into two—"predisposing" and "exciting." This part of my subject has given rise to much speculation and conjecture, and various theories as to the pathology of acute rheumatism have been broached. Is there a special poison, and if so is it introduced from without, as in the case of small-pox, typhoid fever, or ague? or is it manufactured within the body, as in gout or uræmia? Dr. Maclagan has advocated the view that the poison of rheumatic fever is malarious in origin, and although I cannot agree with this, it was a very "happy thought," for it led him to try salicin in the treatment of the disease, and was the means ultimately of introducing the use of salicylate of soda, the value of which is now universally acknowledged. By some authorities the "germ" theory has been entertained, and Professor Pel of Amsterdam, thinks that "it only wants the discovery of the specific micro-organic cause of the disease in the inflamed serous membranes to render the present presumption of its specific origin a certainty."[3] But I do not "cotton" (to use a homely phrase) to the theory that the poison of acute rheumatism is introduced from without. All the evidence appears to me to point to the conclusion that it is manufactured *within* the body. This has been clearly proved to be the case in gout by Sir Alfred Garrod; and Dr. Lauder Brunton has called attention to certain remarkable poisons that are formed during the peptonising of proteids within the living body, which suggests the possibility, to say the least of it, of the *materies morbi* of rheumatic fever being formed during the process of digestion or metabolism. Whether it may be lactic acid, an old idea recently revived by Dr. Fagge, or any other kind of acid, I cannot say. We know that a profuse and acrid sweat accompanies the disorder, and looks like an effort of nature to eliminate the poison; but we also know that no amount of alkalies will neutralise the mischief. Unsatisfactory as it may be, we must, I think, admit that the particular substance the presence of which in the blood predisposes to an attack of acute rheumatism has yet to be discovered.

The liability to rheumatic fever is not the same at all ages. It is amongst the young that the disease is most prevalent, though mere infants do not seem to suffer. Perhaps the most common time of life for an attack is between the ages of ten and thirty, though it may occur in younger and older persons. It is very unusual to meet with a first attack of articular rheumatism after fifty years of age, and even those who have had the disorder ultimately outlive their liability to be attacked by it. Youth, then, must be reckoned as among the predisposing causes of acute rheumatism. A previous attack has been also supposed to increase the liability to the disorder, but about this there is some doubt. The very fact that in course of time the tendency to the complaint is lost would seem to contradict it. Some ten years ago I was the only person who dared to disbelieve the dictum that former attacks predisposed to the disease; but I find now that the late Dr. Fagge, in his work on Medicine, takes the same view. Loss of health or debility in any form no doubt increases the liability to acute rheumatism. It also seems to be inherited, and in some persons there is such a strong tendency to the disorder that the slightest exposure to wet and cold, or to cold only, will bring on an attack, and occasionally no exposure at all can be traced. Other persons are much less liable to rheumatism, and only the most disastrous circumstances will produce the disorder. A large number of the community escape the disease altogether, no matter to what amount of wet and cold they may be exposed. "The most important exciting cause, perhaps the only one worth considering, is exposure to cold, and especially to cold and wet. Sleeping in a damp bed with insufficient clothing, remaining in wet clothes, sitting in a draught of cold air when heated—in fact, getting a 'chill' in any way, will often induce acute rheumatism in those that are disposed to it. Possibly it is the check thus given to the eliminating functions of the skin that determines an attack of the disease. It may be well to mention here that it is wet *and* cold that are so injurious; and if anyone find himself in a damp bed, he may minimise the mischief, perhaps save himself from any harm, by heaping on plenty of clothes, or by getting rid of the sheets and sleeping between the blankets only."[4] In the same way, if we happen to get wet through from any cause, we should keep ourselves warm by sharp exercise until we can get a change of clothing, which ought to be effected at the earliest possible moment.

It is not often that we have the chance of making a post-mortem examination on a case of rheumatic fever during the height of the joint inflammation, but occasionally a case proves fatal from cardiac complications or hyperpyrexia. We then find that the affected joints are more or less vascular, especially about the synovial fringes, and coated with a sticky, altered synovia. Sometimes there is effusion, but more commonly not, because the joint mischief is apt rapidly to subside upon the occurrence of any fatal complications. It is said by Sir Alfred Garrod that no ulceration of the cartilages takes place in true articular rheumatism, even after repeated attacks of the disease; and very rarely, if ever, is pus found in the joints. When a case has proved fatal in consequence of cardiac disease, the post-mortem appearances will be in accordance with the mischief that has arisen during life. When death occurs in consequence of hyperpyrexia, we shall probably find evidence of pericarditis in about half the number of cases. Cardiac complication is not an essence of the high temperature, but only an occasional accompaniment. The post-mortem appearances in hyperpyrexia will generally include a vascular condition of the brain and meninges, a dark and congested state of the lungs; the liver and spleen are friable and easily broken down, and the kidneys usually congested. The blood is tarry and fluid, but the muscles are remarkable for their bright-red colour. These changes, it will be noted, are simply the result of the high fever. The odour of such cases, even when recently examined, is most offensive.

The diagnosis of acute rheumatism is generally so simple and easy that I do not halt here to make any remarks on the subject. The prognosis is eminently favourable as far as the mere issue of the affection of the joints is concerned; but it

[1] Notes on Rheumatism, by Julius Pollock, M.D., second edition, pp. 21 and 22.

[2] Dr. Maclagan on Pyrexia and Hyperpyrexia. THE LANCET, March 12th, 1887.

[3] THE LANCET, Sept. 3rd, 1887, p. 495.

[4] Pollock on Rheumatism, p. 16.

must be guarded (1) in reference to possible cardiac mischief, and (2) the chance of hyperpyrexia, which latter, however, is but a remote contingency. Heart disease is more liable to occur in children; hyperpyrexia in adults. In the chronic forms of true articular rheumatism the prognosis is very favourable.

I now come to the last and most important part of my subject—the treatment of rheumatic fever. A few years ago this was most unsatisfactory. I have seen alkalies, quinine, blistering, and other reputed remedies tried in a large number of cases, alone or in combination, but without being at all impressed by their value; and well might Sir William Jenner, when President of the Clinical Society, express the doubt and uncertainty with which he used to approach the treatment of articular rheumatism under the old *régime*. But some ten or twelve years ago a new and improved method of dealing with the disorder came into operation; and it is only due to Dr. Maclagan that he should have the credit of having been the first to use salicin as a remedy, which ultimately led to the introduction of salicylate of soda, one of its derivatives. I cannot say that I have had much success with salicin, though I have tried it in a number of cases, but he must be blind indeed who cannot perceive the great value of the soda salt. There may be some doubt as to whether its use shortens the duration of rheumatic fever, but beyond question it robs the disease of some of its most painful symptoms. In a few days, sometimes hours, the temperature is brought down, the inflammation and pain in the joints subside, and the patient is in most cases practically convalescent. It is not claimed for salicylate of soda that it will prevent the occurrence of heart complications, or even hyperpyrexia, but it lessens the chance of either mischief by rapidly reducing the fever. It must also be borne in mind that the drug is not an absolute specific. Where shall we find one? It fails to relieve or cannot be tolerated every now and then. But this is no more than what happens with quinine in ague, or iodide of potassium in syphilis. Salicylate of soda sometimes produces sickness, deafness, tinnitus aurium, and a peculiar kind of cerebral disturbance; but these disagreeable effects quickly disappear on a discontinuance of the drug, and seldom return upon its resumption after a short interval. The salicylate has been charged with producing serious cardiac depression, and even causing sudden death; but the evidence on these points is not very clear, and personally I have never witnessed any such effects. In treating a case of articular rheumatism, the salicylate of soda may be given in doses of ten, twenty, or even thirty grains every two, three, or four hours, according to the severity of the symptoms and the effect produced. Where there is evidence of great acidity, some alkali (five to fifteen grains of the bicarbonate of potash) may be usefully combined with each dose of the salicylate, which is best given in some aromatic water to conceal its somewhat acrid taste. It is important to keep up the action of the drug for some days after the disappearance of the fever, as the premature disuse of it is apt to lead to a return of all the symptoms—a so-called relapse. Towards the close of a case of rheumatic fever, the joints are not unfrequently left rather swollen and painful; it is then that iodide of potassium (internally), and iodine paint (externally) are so useful. When quite convalescent, the patient should have tonics, and especially steel and quinine; and if rheumatic pains linger, the salicylate of quinine, in five-grain doses, three times a day, is often of much service. Other salts of salicylic acid will probably be found useful in the treatment of rheumatism; and lately a new preparation, "salol" has been introduced. It is a salicylate of phenol and has been used a good deal in America, with, I believe, satisfactory results. But it may be asked, What is to be done in those cases of articular rheumatism in which the salicylates are not successful? Well, it is unfortunate when this happens, but we may fall back upon large doses of salicin, upon alkalies, or upon the excellent alkaline quinine prescription of Sir Alfred Garrod. Quinine and bicarbonate of potash are rubbed up together with a little mucilage and some aromatic tincture, in such proportions that each ounce and a half of the mixture contains five grains of quinine (in the form of carbonate) and thirty grains of potash. This dose may be given every four hours for as long as may seem desirable.

Of course, all cases of rheumatic fever must be kept in bed, and properly dieted. The most suitable nourishment in the earlier stages is the usual beef-tea and milk "fever" diet, but to this may soon be added some farinaceous food, eggs, and afterwards fish. Rheumatic fever is a disease of debility, and it is very desirable to keep up the strength of the patient; but in some cases the too early resumption of meat has seemed to be followed by a return of the rheumatism. Further information on this point would be of value. Stimulants are not absolutely necessary, nor often needed, in cases of articular rheumatism; but they may be required at times, and should be administered in accordance with the condition of the patient. The bowels should receive attention, but no active purging is required, especially as the movements necessitated by any action of the bowels are attended with considerable pain in severe cases. On the other hand, opium or morphia, which may well be used hypodermically, is often of great service, alleviating the pain in the joints and allowing the patient to get some sleep. When cardiac mischief arises in a case of acute rheumatism, it should be treated in accordance with the plan adopted in such cases, the consideration of which is outside my subject. I must, however, say something about the treatment of hyperpyrexia, a matter of much interest and importance. It is unfortunate that in this severe condition, where most we want its aid, the salicylate of soda, though it was originally introduced as an antipyretic, should entirely fail. Nor can I say much that is favourable of any other of the reputed febrifuges, such as quinine, antipyrin, &c. In truth, we are driven, in the treatment of hyperpyrexia, to the application of external cold, and although some years ago I expressed a very doubtful opinion as to the efficacy of this method, a further knowledge of the subject has led to a considerable modification of my original views. There is now, I think, no question that the careful and judicious use of the cold bath or cold pack holds out the best chance of saving life in these truly formidable cases. The most important precaution would seem to be that the application of cold should be gradually and cautiously applied so as to avoid shock. This may be accomplished by placing the patient at first in a bath the temperature of which is not much below 80° F., and gradually reducing the temperature until the desired effect is produced. This bath may have to be repeated more than once perhaps, and the use at the same time of injections of ice-cold water into the rectum may be of service. Where a bath is not available, or thought to be undesirable for any reason, the cold pack may be tried. In cases where ice is not used, the patient's body and limbs are wrapped closely in a single sheet, which has been previously wrung out of cold water (temperature 50° to 60°). A blanket is then thrown loosely round him, and he is allowed to remain undisturbed for about half an hour, when the same process is gone through again, and repeated until the temperature is sufficiently reduced. When the ice pack is employed, a hip bath, or other suitable receptacle, containing a few gallons of water, in which some large pieces of ice are floating, is kept by the patient's bedside, and his body and each limb are separately wrapped in pieces of old sheeting which have been wrung out of the iced water, each piece being renewed as often as it begins to feel warm to the hand. No other covering of any kind is put over the patient. In this way the temperature may be very rapidly reduced, and it is necessary to be careful that it is not brought too low. It should not be allowed to fall below 99° F. Amongst many others, two cases have recently been reported which tend strongly to show the value of external cold in the treatment of hyperpyrexia. One is by the late Dr. Carrington, at a meeting of the Clinical Society on Feb. 25th last, and the other by Dr. Frederick Taylor, in THE LANCET of March 12th, 1887.

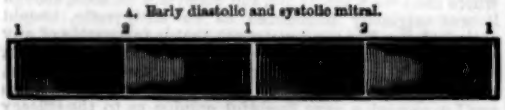
METROPOLITAN POLICE SURGEONS' ASSOCIATION.—At a meeting held on Nov. 3rd, the following officers and Council were elected for the ensuing year:—President: A. O. Mackellar, F.R.C.S. Vice-Presidents: Thos. Bond, F.R.C.S.; Roderick Macdonald, M.P., L.R.C.P. Treasurer: George B. Phillips, M.R.C.S. Hon. Secretaries: H. Nelson Hardy, F.R.C.S. Ed.; J. H. Waters, M.D. Council: Alex. Forsyth, M.D.; D. S. Downes, L.K.Q.C.P.I.; T. C. Murphy, L.R.C.P.; E. K. Hinchin, L.R.C.P.; S. Mills, M.R.C.S.; Geo. Pearse, L.R.C.P.; J. Hammersley, M.R.C.S.; E. C. Barnes, M.R.C.S.; F. J. Bucknell, M.B.; M. Brownfield, L.R.C.P.; G. E. Yarrow M.D.; W. H. Roots, M.R.C.S. This Association has made a good start, with the entire approval of the late chief surgeon and the present chief surgeon, as also of the Commissioners of Police. It is remarkable that such an association has not been formed before.

ON OBSTRUCTIVE MITRAL MURMURS.[1]

BY J. S. BRISTOWE, M.D., LL.D., F.R.S.

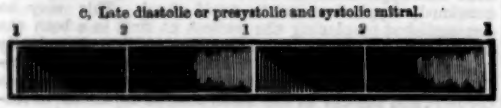
OBSTRUCTIVE mitral murmurs are generally regarded, I believe, as presenting two well-marked varieties, of which the one, named indifferently presystolic or auricular-systolic (Fig. C), occupies the latter part of the diastolic period running up to and culminating in the first sound of the heart, while the other is an ordinary diastolic murmur (Fig. A) commencing from the second cardiac sound, and dying away in the course of the diastolic period. These two murmurs may occur independently of one another or in association, and in the latter case the earlier murmur may either die out before the later murmur begins (Fig. D), or the two may meet and blend (Fig. E), so that the whole period of the diastolic silence becomes occupied by a continuous sound.

A, Early diastolic and systolic mitral.

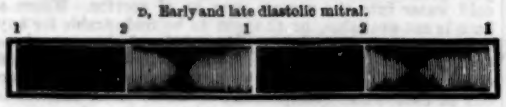


B, Mid-diastolic mitral.

C, Late diastolic or presystolic and systolic mitral.

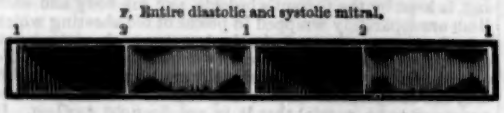


D, Early and late diastolic mitral.



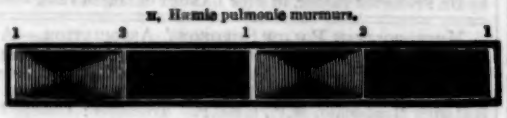
E, Entire diastolic mitral.

F, Entire diastolic and systolic mitral.



G, Entire diastolic mitral running off from the reduplication.

H, Hæmic pulmonic murmurs.



The so-called presystolic murmur is the more common, the more characteristic, and the more interesting of the two. It commences somewhere in the diastolic period, varies in its duration (being sometimes very short, often much prolonged), is singularly rough in character, and usually increases in power from its origin to its close in the first sound of the heart. Various fanciful, and I think mostly meaningless, combinations of letters have been devised to represent its peculiar quality. It closely resembles the trilled "R," or the sound of a saw slowly worked, and its gathering force and explosive termination in the first sound remind one of the breaking of a wave in the hollow of a rock. It is characteristic of the presystolic murmur that (notwithstanding its roughness and loudness as conveyed by the stethoscope) it is usually audible over a very limited area, the centre of which is a little to the right of and above the apex beat; and is inaudible, or at most very slightly heard, in the axilla, or at the angle of the scapula. So far as I know, this murmur, strikingly characteristic as it is now universally acknowledged to be, was not differentiated from the systolic mitral murmur by the older writers. As a student and young physician, I certainly knew nothing about it, and am sure that I (and I believe all my colleagues) regarded it as systolic mitral. I may add that I have always suspected that one chief ground on which it was formerly taught—that in certain forms of heart disease the pulse at the wrist was sensibly delayed—was this prevailing tendency to confound the two chief mitral murmurs.

The early diastolic mitral murmur, like the murmur of aortic regurgitation, runs off from the second cardiac sound, and tends to die out in the diastolic silence. It may generally be well heard in the mitral area, or in the situation which the presystolic murmur mainly effects. As Dr. Balfour remarks, its seat of maximum intensity is not uncommonly the junction of the left fourth cartilage with the sternum; and it may sometimes be heard here dissociated from its presystolic companion. This murmur is not unlike the murmur of aortic regurgitation, but is generally, I am inclined to think, rather shorter, rather more rough, and more sustained. It is rarely, however, as rough as the presystolic murmur, and I should be inclined to liken its sound to that of the untrilled "R." That it may be confounded with the diastolic aortic murmur, even by presumably competent observers, is certain. Only recently in a patient whom I exhibit this evening, a murmur of this kind, which near the apex blended with a loud presystolic murmur, was heard alone over the cartilage of the left fourth rib, and was regarded as a diastolic aortic murmur by one of my colleagues. And a few years ago I had under my care a patient between thirty and forty years of age suffering from cardiac disease, of which he died, who presented congestion of the face, general anasarca, hæmoptysis, and other phenomena generally present in the later stages of mitral disease, and whose sole local sign of cardiac defect (in addition to the fact of some degree of hypertrophy and dilatation) was a diastolic murmur audible only at the apex of the heart. I came to the conclusion, not without some misgiving, that the symptoms were all due to mitral obstruction. But the post-mortem examination showed that I had been deceived; for the mitral orifice was absolutely healthy, and the aortic valves were contracted and allowed of regurgitation. Of course, it is only those aortic regurgitant murmurs which are inaudible over the base of the heart that can possibly be confounded with diastolic mitral murmurs.

Dr. Dickinson calls special attention to a third variety of diastolic mitral murmur, to which I have also given much consideration, and which, if I recollect right, he considers to be the diastolic mitral murmur formerly recognised by Hope and others. I am inclined to think with Hope that Laennec's diastolic mitral murmur was the murmur of aortic regurgitation, and that his own was either that or the diastolic mitral just described, and not the murmur I am about to discuss. The third murmur occurs isolated in the diastolic period (Fig. B), and for the most part nearer to the second sound than to the first. I believe it is often regarded as a simple reduplication of the second sound. But it differs from the lagging factor of the normal second sound, in the facts that it is of longer duration than the second sound, that it is only to be heard in the region which the presystolic murmur affects, and that it occurs independently of any reduplication of the second sound audible at the base of the heart. The murmur is generally feeble, but varies in duration, and when more than usually prolonged presents obvious traces of the presystolic trill. The rhythmical relations of this murmur and the two sounds of the heart may be represented by a dactyl, of which the first syllable corresponds to the first sound, the second syllable to the second sound, and the third syllable to the murmur. They are better represented if the final syllable of the dactyl be made long instead of short. They may also be aptly represented by the word γεγραφα, which a distinguished colleague of mine used some years ago in illustration of such a case. I do not

[1] Read before the Medical Society of London on Monday, Nov. 7th.

know what his present views of this special murmur may be, but at the time to which I refer I believe he regarded the case of which he used this illustrative word as one of simple reduplication of the second sound. The case, however, had been under my observation for several years, and several times in the hospital under my care. It was one which I regarded during the whole of this period as an example of obstructive mitral disease, but in which, while the presystolic murmur was never audible, the short murmur following the second sound near the apex and undistinguishable at the base was always present, and in which I was able to trace the gradual enlargement of the right side of the heart, and the consequent development of a regurgitant tricuspid murmur and its permanent establishment.

The three murmurs above described (which might, I think, be conveniently termed the early, the mid, and the late diastolic mitral murmurs respectively) may exist either separately or combined; and in the latter case may constitute a continuous but uneven murmur, beginning from the second sound, ending with the first, and filling up the whole of the diastolic period; so that the acoustic phenomena of the heart as presented at the apex shall consist only of a series of alternate prolonged roars and briefer periods of silence. (Figs. E and F.) There seems to me no reasonable doubt that these three murmurs, although they frequently occur independently of one another (so frequently, indeed, and so characteristically as to demand individual description and separate recognition), are only parts of a potential murmur filling up the whole of the diastolic period; or, in other words, that they are the fitful, and in a sense accidental, roarings of a continuous torrent. This view seems to me to be confirmed (if confirmation be necessary) by two easily observed facts. The one is, that each one of the murmurs is liable to come and go as no other organic cardiac murmur comes and goes, and that they are liable (especially the latter two) to alternate with or to replace one another. The other is that, although the earlier two sounds are often feeble and somewhat indeterminate in character, when they blend with one another and with the presystolic murmur and become louder, they present all that vibratile roughness of quality which is so characteristic a feature of the generally more noisy and obtrusive member of the firm. In the case of the patient already referred to in the adjoining room, and in whom the condition of the prolonged diastolic murmur has varied somewhat from time to time, I observed on one occasion (and those who were with me and examined her will confirm my statement) that the roughest and loudest portion of the whole-length diastolic murmur was its middle half (Fig. F). I have observed the same thing in other cases.

There are one or two matters in connexion with mitral obstructive disease and the murmur it occasions to which I should like to advert.

The condition of the second sound of the heart in these cases has always been a subject of interest and study. It need scarcely be said that in mitral obstructive disease, as well as in mitral regurgitant disease, and indeed in all affections which oppose an obstacle to the transit of the blood from the pulmonary artery to the left side of the heart, and in which consequently the right ventricle becomes enlarged and the pulmonary artery dilated, the second sound over the pulmonic area becomes accentuated, while that over the aortic area either remains unchanged or undergoes enfeeblement. Further, it is generally recognised that in cases of mitral obstruction there is a marked tendency to reduplication of the second sound. As regards the actual or relative enfeeblement of that portion of the second sound due to the aortic valves, it is obvious that if there be such enfeeblement over the aortic area (where this sound is always best heard), there must be proportionate enfeeblement at the extreme apex of the left ventricle, and that occasionally it will be heard with difficulty at that spot. It is said, indeed, that in some cases it becomes inaudible there. No doubt such cases are met with, for one occasionally observes the extinction of the second sound in this locality in other forms of heart disease. But I cannot call to mind any example of mitral obstruction in which I have been unable to detect the second sound at the apex. The only case, indeed, in which it has seemed to me possible to ignore its presence is that in which the enfeebled second sound is lost in the noisy commencement of a prolonged diastolic mitral roar. The reduplication of the second sound is certainly a common accompaniment of mitral obstruction; but it is a very variable phenomenon, and is apt to come and go in the same case. The reduplication seems due to the lagging of the aortic valves. The second sound is of necessity loudest, and its reduplication necessarily most distinct at the base of the heart in the neighbourhood of the valves. Reduplication of the second sound, audible only at the apex, is therefore an impossibility. It is for this reason, amongst others, that the mid-diastolic mitral murmur, which may simulate reduplication and has been mistaken for it, cannot be of pulmonic or aortic origin. But reduplication of the second sound in cases of mitral obstruction is not infrequently audible at the apex as well as at the base; and an interesting example of this fact has been more than once furnished by the patient already once or twice referred to, in whom the second sound is sometimes single, sometimes double, and in whom, when such reduplication is present, the prolonged diastolic mitral roar starts from the repeated second sound, thus leaving the second sound at the apex apparently normal, and allowing of a momentary interval of silence between it and the murmur. (Fig. G.) I believe that this phenomenon is always observable when the second sound is reduplicated, and the mitral murmur is of the early diastolic kind.

The presence of a thrill over and about the spot on the surface of the chest at which the heart's apex impinges has always been recognised as a characteristic accompaniment, not only of the presystolic murmur, but also of the noiseless rush of blood through a contracted mitral orifice. There can be no doubt, I think, that an apex thrill is in a very large proportion of cases diagnostic of mitral obstruction, and that it is generally due to the rhythmic vibrations of the blood entering the ventricle from the auricle, on which also the characteristic rough murmur depends. By most observers it is said distinctly to occur while the presystolic murmur proper is, or should be, in progress and the contraction of the auricle presumably is taking place. Dr. Galabin's cardiographic tracings seem quite to confirm this relation. But when the rough murmur occupies the whole of the diastolic period, the thrill also (as nearly as may be) is equally lengthy; and when the murmur is roughest in the mid-diastolic period the thrill is most marked during the same interval. Yet I am bound to admit that, so far as I can make out the only, or at any rate the most marked, thrill seems occasionally to accompany the ventricular systole. In a case at present under my care in which a hæmic pulmonary murmur is associated with a double mitral murmur, the apex thrill was certainly at one time mainly systolic. But the heart was beating rapidly (over 100 in the minute), and the thrill (as I think the cardiographic tracing confirms) was due to the successive rises and falls which even in health are apt to appear on the broad summit of the excursion representing the cardiac systole.

The association of a true regurgitant or systolic mitral murmur with an obstructive murmur at the same orifice is by no means uncommon. In most cases the first sound of the heart terminates the one and starts the other (Figs. C and F); in other words, a presystolic murmur and a systolic murmur are made continuous by the intervention of the first cardiac sound. Under these circumstances the two murmurs are generally, I believe always, absolutely distinct from one another, both in relation to the apex beat and the pulse, in the quality of their sounds, and in respect of the areas over which they may be respectively best heard. The presystolic sound definitely precedes the apex beat, but runs up to it, and equally definitely precedes the carotid pulse; while the commencement of the other coincides accurately with the apex beat and the pulse. The presystolic murmur is always rough, and generally increases in roughness and loudness until it blends with the first sound; the other, with very rare exceptions, is either musical or blowing and dies away into silence. Indeed, the sudden transition from the one kind of sound to the other is a very striking phenomenon. I admit that occasionally at the apex of the heart a short rumbling murmur is heard about the beginning of the ventricular systole, the exact relations of which it is difficult to determine; and that I am disposed at times to regard such brief murmurs as systolic, at times as presystolic, at times as ill-defined combinations of the two. My belief, however, is that (as the peculiar roughness of such sounds and their comparatively abrupt termination seem to imply) they are really presystolic. Again, the presystolic murmur (as has before been

pointed out) is heard over a very small area, and is not only generally audible in the axilla, below the angle of the scapula and at the base of the heart, but often fails to reach even the true apex. On the other hand, the mitral systolic associated with it may not only be heard where the presystolic is also heard, but extends in a greater or less degree into all the districts above specified. It may be recognised in most of them, and often at the apex, without even a trace of its presystolic accompaniment. In a small but interesting proportion of cases the systolic mitral is associated with a true diastolic mitral, as in a patient whom I saw a day or two since in King's College Hospital (Fig. A). In this instance there is a double murmur, best heard in the neighbourhood of the apex, of which the systolic element is prolonged and blowing, not unlike a diastolic aortic murmur, while the diastolic mitral, which runs off from the second sound, is of rougher quality, resembling an untrilled "R," is uniform in power, and ends somewhat abruptly.

I now come to the consideration of that question which Dr. Dickinson has discussed with great felicity of language and undeniable dialectical skill—viz., "*How are the murmurs which accompany and indicate mitral obstruction produced?*" I must confess that to my mind the problem appears to be free from all real difficulty, and that I entirely accept the explanation formulated by Dr. Gairdner many years ago. I believe that all the different varieties of murmur of mitral origin occurring between the second and first sounds of the heart are due to rhythmical vibrations, or (if it be preferred so to express it) to fluid veins, determined by the passage of blood from the auricle through the contracted mitral orifice into the ventricle; and that the reason why the so-called presystolic murmur is more common than the murmurs arising in the earlier part of the diastolic period, and is for the most part coarser and rougher than they, is that, as physiologists teach us, the systole of the auricle immediately precedes the systole of the ventricle and the occurrence of the first sound of the heart, and causes, while it lasts, a specially forcible current from the one cavity to the other. That the earlier diastolic mitral murmurs—viz., those running off from the second sound, and those that are isolated in the mid-diastolic period—are direct, no one, so far as I know, denies, and Dr. Dickinson himself believes. But if such an explanation is regarded as sufficient for murmurs developed from or shortly after the second sound of the heart, why should it not equally apply to murmurs occurring just before, and running up to, the first sound? Surely the fact that the contraction of the auricle at that time renders the flow of blood more rapid than it was before furnishes no intelligible reason for discarding the auricular systole as the principal agent in the production of such murmurs.

The reasons in favour of the view that the presystolic murmur (which is alone in dispute) is determined by the onward flow of blood from the auricle to the ventricle are mainly as follows:—1. It accords with the physiological fact that the contraction of the auricle, to which it is attributed, immediately precedes, and runs on into, the ventricular systole, the very commencement of which is timed by the first sound of the heart, in which the presystolic murmur itself ends. 2. The murmur precedes the arterial pulse, ends with the apex beat, and occupies a time, therefore, in the cardiac cycle, which would otherwise be a time of silence, and a time which we have always been taught to regard as the close of the cardiac diastole. 3. The presystolic murmur does not differ in quality from the diastolic mitral murmurs of earlier period. It is true that the latter are for the most part feebler, but though feeble they are generally characteristically rough, and not very unfrequently they present a degree of roughness which equals or surpasses that of the presystolic murmur itself. 4. All the different kinds of mitral obstructive murmurs are equally characterised by consonantal noisiness, and consonantal want of penetrating power, and thus are always audible over a curiously restricted area. 5. They are not conveyed into the axilla or to the angle of the scapula as systolic mitral murmurs are conducted, and as they would certainly also be conducted were they due to regurgitation.

Among the arguments which are adduced on the opposite side of the question are the following:—1. The force with which the blood is driven into the ventricle by the contractions of the thin-walled auricle is insufficient to cause the roughness and loudness of sound distinctive of the murmur in question. In answer to this, it would seem sufficient to to say that equally loud and rough murmurs may be developed during the earlier part of the diastolic period, when the force of the blood current is chiefly dependent on the suction exercised by the expanding ventricle. But it is a mistake to suppose that the loudness and roughness of the presystolic murmur need much velocity of current for their production. The murmur, as I have before stated, is like a trilled "R," and is made up of coarse vibrations, which follow one another far too slowly to cause a musical note. There is no such forcible escape of air in the production of the trilled "R," as there is in whistling or simply blowing. Rather, the breath escapes in volume, but slowly, past the vibrating barrier. I do not argue that the slower the current the louder should be the characteristic murmur; but I hold that moderate rapidity is best adapted for its production, and that greater rapidity would probably convert the trill either into a musical note or into a noiseless whiff. 2. The running of the presystolic murmur into the systolic mitral murmur (when the two sounds coexist), without any discernible interval between them excepting that due to the presence of the first sound (which, in fact, unites them), is held to prove that the two murmurs must be due to a single action, and consequently to the contraction of the ventricle alone. It is argued that if the former of the two sounds is produced by the contraction of the auricle and during the flow of blood from the auricle into the ventricle, and the second is (as everyone acknowledges it is) caused by the contraction of the ventricle and the reversal of the blood current through the insufficiently protected mitral orifice, there must of necessity be a momentary interval of silence between the end of the presystolic murmur and the first sound of the heart, from which the later murmur starts; just as there is an interval of silence between each pair of respiratory acts, and a momentary pause between the end of a swing of the pendulum and the beginning of the one following, or (to take an even more apposite example), as there certainly is, between the successive elements of a to-and-fro aortic murmur. Such illustrations are valuable as helping to make clear the point of view of those who quote them; but they are of little value in determining the question at issue, unless it can be shown that their conditions are identical with, or analogous to, the conditions of the problems to be solved. I do not think that such is the case here. As I understand the action of the heart, and I believe it is the view which is generally taught by physiologists, the contractions of the auricle and ventricle are not so much an alternate contraction of these two cavities, as they are a rapid peristaltic movement beginning in the auricle and continued without pause into the contraction of the ventricle. If that be the case, even though there be a real reversal of the current between the auricle and ventricle at the moment when, on the cessation of the auricular systole, the ventricle begins to contract, no pause between the two actions is necessitated, and none need be assumed. Even if there were a pause, it might be so short that the ear would be unable to detect it. There is no audible break, so far as I know, in a prolonged, presumably continuous, note on the violin made by a competent player with a to-and-fro sweep of his bow. Nor is it difficult, I think, to utter with the lips a continuous noise determined by alternate inspirations and expirations. No doubt the inspiratory and expiratory sounds must differ from one another in quality; but that does not imply discontinuity in time. 3. It is argued that the presystolic murmur is produced in a period corresponding to what in the healthily acting heart might be termed the early silent stage of the ventricular contraction, or a brief period of contraction immediately preceding the closure of the mitral valves; that, owing to the leisurely closure of the thick and clumsy curtains when mitral obstructive disease is present, this period becomes prolonged, and that while it lasts the blood in regurgitating is a continually diminishing stream until the actual closure is effected with the snap of the first sound. I must confess that this explanation, ingenious as I admit it to be, seems to me altogether gratuitous. I am not aware that there is any sufficient anatomical or physiological basis for any such hypothesis; and it seems to me, as I have already incidentally tried to show, contradicted by the other clinical facts which are associated with the presystolic murmur. If the length of this murmur at the apex be a measure of the time during which the ventricle is contracting upon its contents before the advent of the first sound, there ought (when obstructive aortic disease is associated with obstructive mitral disease)

to be also a presystolic aortic murmur. Is any such murmur ever heard? Again, if during all this period the blood is flowing backwards into the auricle, it must also be flowing simultaneously onwards into the arteries, and the radial and carotid pulses (or, at any rate, their commencements) should be coincident with the beginning of the presystolic murmur. But the pulse in these cases, as in all others, is simultaneous with the apex beat and the first sound of the heart. Again, how are those cases to be explained in which, as in that of my patient, the whole interval between the second and first sound is occupied by a continuous roar? Must we assume that the whole of this period, as well as the period of silence, is occupied with the ventricular systole, leaving no room whatever for the diastole? Or must we assume that the cardiac incidents become so much disarranged that the first sound, instead of ushering in the ventricular systole (as it should do), ends it, and that the deposed ventricular diastole has to fit itself to the interval between the first and second sound? I know how these questions might be answered by those who accept Dr. Barclay's views; but the obvious answer involves an admission which is practically destructive of them.

Before concluding my paper, I should like to say a word or two with regard to a murmur, or group of murmurs, which has in many respects a striking resemblance to the group of obstructive mitral murmurs. I mean the murmurs often termed hæmic, which are generally best heard about the sternal end of the cartilage of the left third rib, and which may extend into the contiguous portions of the second and third interspaces, and even be prolonged a little way down the left half of the sternum. The murmurs in question are harsh and rough, not like a trilled "R," but sharper and more scratchy (as I believe the late Dr. Sibson described them). They are so rough in quality, and their roughnesses are so distinct, that they are undoubtedly suggestive of pericardial friction, and are not unfrequently, I believe, assumed to be due to the presence of recent or old pericardial lymph beneath the area over which they are heard. It would be difficult for a tyro not to believe that they are due to organic diseases within or outside the pulmonary artery or conus arteriosus. Their main peculiarity, apart from roughness, is that they tend to occupy the whole of the systolic period. (Fig. H.) In some instances the murmur runs off from the first sound, and dies away, like a systolic aortic murmur does, during the systolic period; in some it occurs mainly, if not alone, during the latter part of the systolic period, and, gathering force in its progress, runs into the second sound, which is usually markedly accentuated; while in some, again (and one of the patients whom I have brought with me exemplifies the fact), the murmur occupies the whole of the systole, running off from the first sound, becoming comparatively feeble in the mid-systolic period, and increasing again in volume as it approaches the second sound. Whether such a murmur is ever due to disease of the pulmonic valve or pulmonary artery I cannot say. But I am quite sure, and have proved it to myself by post-mortem examination and by clinical observation, that in the great majority of cases it occurs in connexion with structurally healthy right ventricles, pulmonary arteries, and pulmonic valves, and that the murmur is therefore a so-called functional murmur. How it is caused I do not pretend to decide. That (although it largely occurs in anæmic persons) it is directly due to altered quality of the blood I do not in the least believe. I should think it is connected with some want of due relation between the quantity of blood expelled from the ventricle in a given time and the size or tension of the pulmonary artery, allowing of the development of coarse vibrations of the contents and walls of that part of the circulatory apparatus over which it is best heard. So far as I can see, the occurrence of prediastolic pulmonic murmurs in cases in which the parts concerned are structurally healthy favours the general belief that presystolic murmurs (which so much resemble them) are direct murmurs arising during the onward flow of blood. I see by THE LANCET of last Saturday that Dr. Charlewood Turner, on the assumption that such pulmonic murmurs are due to organic disease of the pulmonic valves, attributes them to regurgitation occurring at the pulmonic orifice prior to the complete closure of the pulmonic valves and the occurrence of the second sound; and quotes this supposed fact as an additional argument in favour of Dr. Barclay and his disciples' views as to the causation of the mitral presystolic murmur.

A REPORT OF CASES (SURGICAL AND MEDICAL).

BY J. HARRIS JONES, L.R.C.P. EDIN., L.F.P.S. GLASG.

(*Concluded from page 910.*)

Pyo-nephrosis; nephrotomy; cure. — Mrs. W——, aged forty-four years, was seen by me on the 11th of December last. Her health had been very indifferent for years. She complained of severe pain in the right lumbar region, which was generally accompanied by considerable uneasiness in the neck of the bladder. Micturition was frequent and painful, and for the last eighteen months she had been constantly passing "matter" with her urine. About ten years ago, after an unusual exertion, she observed blood in the urine on one occasion. She dates her present illness from that period. A year ago last September she felt a "lump" in her side, which slowly increased in size, and gradually approached towards the middle line of the abdomen. Early last summer she voided a very large amount of pus per urethram, and she thinks that some also escaped from the bowels. This had the effect of considerably diminishing the size of the tumour. Soon after, however, it grew to its former dimensions, and had remained at about its present size for the last six months. She had been under the care of several physicians, and had taken a great deal of medicine. Her disease had been variously diagnosed and treated. When I saw her she had been confined to her bed for about three months. Her complexion was very sallow, and she was greatly emaciated. Upon examination, I discovered a tumour stretching diagonally across the abdomen, commencing on the right side from beneath the floating ribs, and extending to a point two inches below the umbilicus and a little beyond the linea alba. It was deep-seated. When pressed upon, it gave an indistinct sensation of elasticity, but no fluctuation could be detected in it. There was no fulness in the right loin. The ascending colon was recognised by its resonance lying in front of the growth, but instead of following its usual upward course it had been pushed forward by the tumour to within a few inches of the middle line of the abdomen. The urine contained a large amount of pus, and was consequently albuminous. Under the microscope the slide was seen studded with pus corpuscles. The patient and her friends, having been told by previous medical attendants that surgical interference would be of no avail in this case, were much opposed to an operation, but after much persuasion on my part they reluctantly consented to an aspiration, and if the sac refilled they would permit me to cut down upon the abscess. On Dec. 27th, with the assistance of Dr. G. W. Guthrie (who a few days previously had seen the case with me), I inserted a needle at a point a little in front of the anterior extremity of the last rib, and aspirated about six ounces of very thick and foul-smelling pus. The operation gave some relief, and for a few days afterwards the urine was freer of pus and had increased in quantity. It was but a short time, however, before the sac refilled and all the old symptoms returned. On Jan. 4th it was noted that she was rapidly sinking, and that life could exist but a few days longer. Consent was given to perform nephrotomy the following morning. On the 5th the patient appeared to be weaker, and it was feared she might die under the operation. Having secured the assistance of Drs. Guthrie and Long, we decided to operate in spite of all odds.

Operation.—The patient took the ether very badly, and it was with much difficulty that the heart was kept beating until the operation was completed. She was turned on her side and the incision was made a little further from the spine than is generally recommended. It was deemed perfectly safe to do so, as the colon and peritoneum had been lifted several inches forward by the tumour, and I felt that by making it here I should likely strike the edge of the kidney and enter the sac at once. The different layers of muscles were divided upon a director to the extent of two and a half inches. A layer of adipose tissue bulged into the spinal end of the wound, and, after clearing it away, the edge of the kidney and sac was reached. A probe was inserted into it, and pus escaped. The opening was enlarged to the extent of the superficial wound, and the finger intro-

duced. About ten ounces of pus were liberated. The parts were thoroughly searched with finger and probe, but no stone could be discovered. When my finger was in the pelvis of the kidney (which was now converted into a large sac) the opening of the ureter was distinctly felt. It was patent, but the tissues surrounding it were very much indurated and thickened. The cavity was washed out with a solution of perchloride of mercury (1 in 2000), and a large drainage tube inserted.

The patient for several hours after the operation wavered between life and death, but with the aid of hypodermic injections of ammonia and whisky, and hot bottles applied to the sides and feet, reaction was finally established. She improved very rapidly after this. Vomiting, which had been a constant annoyance before, ceased, and her appetite soon became voracious. The urine voided a few hours after the operation was slightly bloody, but in a day or two it became "clearer than it had been for years." On the eleventh day it did not contain a trace of albumen or of pus. I have examined it on several occasions since, the last time about a month ago, but have never succeeded in discovering any abnormality in it. The wound was washed daily with an antiseptic solution. It has not, however, completely healed. A sinus remains, which has so far baffled every treatment. It gives very little annoyance, and the discharge from it is scanty and watery. Strangely, a polypus was seen growing into it, and I attempted its removal by torsion on two occasions, but each time it broke off and only a portion was removed. On the third attempt I succeeded in completely removing it. It measured about two inches and a half in length, and tapered at its base to a mere thread. This was accomplished about three months ago, and there has been no indication of its return. My patient, I am pleased to say, enjoys good health, and the only discomfort she experiences from the sinus is when the exuberant granulations at its mouth have to be touched with a caustic.

Rectal Tumours of peculiar growth; removal; recovery.—Mrs. H——, aged sixty-three years, had been complaining for the past two years of symptoms very closely resembling those of chronic dysentery. She felt as if the bowels constantly required to be moved, and when she went to stool she could pass nothing but a little blood and slime. The tenesmus and tormina accompanying the act were almost unbearable, and were rapidly exhausting the little strength she had. She did not remember how long it was since she had a natural fæcal passage, but it must have been at least two years ago. She had undergone much treatment for "dysentery and ulceration of the bowels," but had received no benefit, and, instead of improving, she was rapidly growing worse. Her family physician (who had been taken ill and compelled to leave for change of air) had detected several small tumours in the abdomen. They were supposed to be glandular enlargements, and were treated with an iodine ointment. They rapidly disappeared; but one, which was larger than the rest, remained. When I saw her in March last, I could distinctly feel a tumour, apparently about the size of a small orange, situated in the left iliac region, and lying closely to, and on a level with, the anterior superior spinous process of the ilium. It was slightly movable. A few days after, when making an examination with the finger of one hand inserted in the rectum and a finger of the other hand in the vagina, I distinctly felt from the latter opening a round growth lying high up between the rectum and the vaginal wall, which when pressed upon in a backward direction could be faintly touched with the finger in the rectum. The tenesmus continuing had the effect of bringing the growth a little lower. As soon as the former subsided the tumour would recede beyond reach, and could be felt occupying the position previously stated in the abdomen. The constant pain began to tell upon the patient's strength, and I decided to remove the growth as soon as it would come down within reach.

Operation.—On April 23rd, with the assistance of Drs. Mayer and Long, the patient was etherised, and although the tumour was lying high in the rectum we resolved to remove it if possible. Having first thoroughly dilated the sphincter ani with my fingers, the hand was introduced into the rectum, and the growth grasped. Traction was tried, but owing to the friability of the tumour it was not persevered with. The pedicle was felt to be immensely broad and thick, but no pulsation could be detected in it. With the assistance of Dr. Mayer, a needle containing a double ligature of whipcord was with great difficulty inserted through the pedicle, and one half of it was encircled and tied. The other ligature having become displaced, and finding that the hæmorrhage had been insignificant, we decided to leave the remaining portion untied. The growth was easily peeled off with the finger. After its removal it was found to consist of three separate tumours. The largest was about the size of a pullet's egg, the other two were much smaller. Sections of them were made and examined. Under the microscope they appeared to have the characteristics of a myxoma.

There has been no return of the growths. The tenesmus ceased immediately after the operation, and the patient's health rapidly improved. The bowels are now regular, and the fæces are naturally formed. The severe dilatation to which the sphincter was subjected did not impair it in any way.

Purpura Hæmorrhagica Syphilitica occurring in an infant four days old; death.—On April 19th of the present year Mrs. L—— was confined for the third time. Labour was short and easy; but the placenta not coming away, I was sent for to remove it. The child, a male, looked healthy and strong. Knowing that the father was syphilitic, and that the other children had died in infancy, the last one from syphilis, I requested the mother to send for me if she noticed anything wrong with the infant. On the fourth day I was sent for. The child had been bleeding slightly from the umbilicus. Having requested the nurse to divest it of all its clothing, I observed several large purple patches scattered over the chest, abdomen, and armpits. They were unmistakably purpuric. There had been some bleeding from the nose, and the nurse told me that she had observed a little blood on the napkin that morning. Small doses of mercury and chalk and a mixture of iron and cod-liver oil emulsion were prescribed for it. The child continued to grow worse. Fresh purpuric spots appeared, and the epistaxis and melæna increased in severity. The urine on a few occasions was bloody. The child died on the eleventh day.

Remarks.—I have reported this case for two reasons. Firstly, because of the extreme rarity of purpura in so young a child, and, secondly, on account of the doubt which exists in the minds of syphilographers as to the existence of a syphilitic form of this disease. I could assign no cause for purpura in this case, other than that of syphilis, and I think that I have sufficient evidence to justify the opinion that it was an expression of that dyscrasia.

Wilkes-Barre, Pennsylvania.

ON THE ACTION OF CERTAIN DRUGS ON THE CIRCULATION AND SECRETION OF THE KIDNEY.[1]

BY C. D. F. PHILLIPS, M.D., F.R.S.E.

THE following paper, which is compressed to the smallest possible space, is founded on experiments undertaken by me, in conjunction with Mr. Rose Bradford, in the Physiological Laboratory of University College, London.

The evidence at present obtainable from experimental pharmacology as to the precise mode of action of diuretics is by no means satisfactory. The question is a complicated one. Merely to observe the effects of any drug on the urinary flow and the blood pressure is a fallacious method; the important factor, which is omitted, is the effect of the drug on the *renal bloodvessels*. It does not necessarily follow that a drug has the same action on all peripheral vessels, and it is quite conceivable that it may constrict those of one area and dilate those of another. This is particularly true of the kidney vessels, where the flow of urine is not so much dependent on the general blood pressure as on the difference between the renal vessels and those of the body at large. Thus an ideal diuretic would be one that dilated the bloodvessels of the kidney, but constricted all others in the body. On account of considerations such as these, it occurred to Mr. Rose Bradford and myself that it would be well to reinvestigate the action of drugs on the kidney from a rather different standpoint to that usually adopted.

Mosso and others have investigated the peripheral circulation by enclosing a portion of the body, such as the arm or

[1] Paper read at the Ninth International Medical Congress, held at Washington.

eg, in a rigid vessel filled with fluid and communicating with a delicate registering apparatus, so that any expansion of the limb would, by causing on outflow of fluid, produce a movement of the registering apparatus, which could be recorded graphically on the blackened surface of a revolving drum. Dr. Roy of Cambridge has extended this method to other organs, such as the heart and kidney. In this method the kidney is enclosed in a metal box filled with warm oil, the box being of such construction that no oil is allowed to leak out, and at the same time the structures at the hilus of the organ (vessels, ureter, and nerves) are not injuriously pressed on. This is effected by the box or oncometer being made in two similar halves, and each half having a piece of peritoneum (specially prepared) applied to it in such a manner that the space between the membrane and wall of the oncometer can be filled with oil. The two halves of the instrument are hinged together, and the kidney placed between the corresponding membranes of opposite halves. This membrane, being very flexible, applies itself acurately to the kidney, so that, to use a simile, the kidney placed in the oncometer resembles, for instance, the heart enclosed in the pericardium full of fluid. The heart would represent the kidney, and the visceral layer of the pericardium the delicate membrane of the oncometer; the pericardial sac finding its equivalent in the oncometer, and the pericardial fluid in the oil filling the instrument. It is obvious, then, that if the oil in the oncometer be placed in communication with a recording apparatus, any expansion of the kidney can be readily detected, and recorded graphically in the usual manner. The recording instrument is called by Dr. Roy the oncograph, to distinguish it from the oncometer. Its exceeding delicacy is shown by the fact that the tracing obtained in this manner from the kidney, say of the dog, is practically identical with a simultaneous tracing of the carotid blood pressure; the slight expansions of the kidney caused by each heart beat, as well as those caused by the respiratory undulations of the blood pressure, being perfectly recorded by this instrument. If, now, in the same animal, we record simultaneously the general blood pressure, the expansion and contraction of the kidney, and the excretion of every drop of urine, we can determine the action of any given drug much more completely than before. Our method of experimentation was shortly as follows. The animal (cat or dog) having been anæsthetised with chloroform, or with chloroform and morphia, a cannula was placed in the usual manner in the carotid. The kidney was then exposed, carefully separated from surrounding structures, and placed in the oncometer, this having been previously filled with oil. A cannula was then placed in the ureter, and each drop of urine falling from it was made to break a circuit through an electro-magnetic arrangement, so as to make a mark on the recording surface for each drop. Before commencing the actual experiment, the animal was curarised to prevent any movements, and artificial respiration was maintained. Finally, a cannula was placed in the external jugular for injection of the drugs experimented with. In an experiment performed in this way, the blood-pressure curve and the kidney curve remain constant for several hours. The flow of urine is also very constant in its rate in the same animal, but varies in different animals. It is important that the amount of chloroform administered should be constant. This was effected by blowing the air from the artificial respiration apparatus through a bottle containing chloroform.

We will now pass to the action of various drugs, taking first citrate of caffeine. The effects produced by half-grain doses are as follows: 1. On the *blood pressure*. The blood-pressure is first lowered, and then is raised. Both effects are of short duration and slight, especially the rise of pressure. 2. On the *heart*, there is first a diminution in the force of the beats, followed by a slowing, with beats of markedly increased force. 3. On the *kidney*, there is at first contraction lasting two or three minutes, and accompanied by diminution or even arrest of secretion. This is followed by expansion, which (after a one-grain dose) lasts sometimes over half an hour, the flow of urine being simultaneously trebled. The effects on the kidney cannot be the result of the changes in the general blood pressure; this is shown by the fact that they do not occur simultaneously. The effects on the general pressure are slight and last only a few seconds, those on the kidney being measured by minutes.

Another drug which acts in a similar way is ulexin, a new alkaloid obtained from the seeds of the common gorse (Ulex Europæus). It has the objection that in animals the diuretic action is only maintained with doses which would either kill through the respiration or produce violent convulsions. It resembles caffeine in producing first a constriction and then an expansion of the renal vessels, with diuresis. It differs from caffeine in three particulars: 1. It is more powerful. 2. Its effects are more transitory. 3. Repeated doses of caffeine rapidly injected produce contraction only of the kidney, not followed by expansion; but similar excess of ulexin causes only expansion without contraction.

Among other substances that cause expansion of the kidney we may cite dextrose, urea, acetate and chloride of sodium, and probably all the constituents of the urine.

The drugs producing constriction of the kidney are more numerous. Digitalin in doses of $\frac{1}{75}$ gr. causes contraction, which persists for as long as half an hour. It is not easy to decide whether digitalis is a true diuretic, or only exerts its effects through the heart. During the contraction of the kidney, however, the flow of urine is not diminished, as is the case with caffeine, but is generally increased. The explanation seems to lie in the effect on the general blood pressure, digitalin raising it, caffeine depressing it. Spartein, on the other hand, though it acts similarly to digitalin on the heart, general blood pressure, and renal vessels, causes a great diminution of urine; and in disease, its so-called diuretic effect is due to improvement of the general circulation. We have also made many observations with strophanthin and apocynëin; their chief action is on the heart muscle; they produce little or no effect on the peripheral vessels. Both cause a slight temporary contraction of the kidney vessels, but with no definite increase in the urinary secretion. Finally, turpentine, adonidin, and barium chloride all produce marked contraction of the kidney, without diuresis.

In summing up the results, we see that reputed diuretics more commonly produce contraction of the renal vessels than expansion. Further, that expansion is either slight, as by acetate of soda; or, if large, as by citrate of caffeine, is only produced by small and initial doses. The powerful action of ulexin on the respiratory mechanism is a great drawback to its use; one-sixth of a grain was used in our experiments, but one-twelfth of a grain would completely arrest respiration. Then, again, such drugs as produce contraction of the kidney cannot be bracketed together, since, though they all have the same effect on blood pressure, digitalin alone has an obviously diuretic effect. We further see evidence of the truth that the flow of urine is not so much dependent on blood pressure as on the rate of the flow of blood in the renal vessels. It is necessary also to remember that although such drugs as strophantin produce a great increase in the force of the cardiac beats, yet the heart is very much slowed, so that it is possible that the amount of blood sent into such an organ as the kidney in a given time may remain the same; whereas such a drug as digitalis, producing a rise of blood pressure and a contraction of the kidney vessels, may cause an increased quantity of blood to pass through those vessels, and thus it acts as a diuretic. Inasmuch as spartein has not a marked diuretic action, we must also assume that digitalin has some peripheral action on the secretory apparatus of the kidney.

Our results may be tabulated briefly as follows, in three divisions:—

A. Drugs that first *contract* and afterwards *dilate* the kidney. I shall mention two out of this class: 1. Caffeine, in small doses, induces in the stage of contraction a fall of blood pressure; in that of expansion, a slight rise. During the former, the flow of urine may be arrested; during the latter it is always increased, *such increase depending on dilatation of renal vessels*. The possible arrest of secretion during the first stage is special to caffeine, and may be induced by large or repeated doses. 2. Ulexin, one-sixth of a grain, greatly raises blood pressure during the first stage (that of contraction); in the second, expansion is much greater in degree but shorter in duration than under caffeine, and is accompanied by brief but marked increase in urinary flow: the effective dose is limited by its toxic action on respiratory centres. Practically, excess of caffeine induces only the first stage, excess of ulexin only the second.

B. Substances that dilate the kidney, but to less extent and more slowly than caffeine and ulexin, are dextrose, urea, sodium, chloride and acetate, and probably all constituents of the urine.

C. Drugs that contract the kidney without subsequent expansion:—(1) Digitalin, with increased secretion of

urine—probably resulting from general heightened blood-pressure. (2) Spartein, with diminished secretion—in health at least. (3) Strophanthin causes slight temporary contraction, with no marked increase of secretion. (4) Apocynëin, similar temporary contraction, and no definite increase of secretion. (5) Turpentine, (6) adonidin, and (7) varium chloride give similar results.

In conclusion, it seems to us that the plethysmographic method of experimentation is a valuable one for determining the exact action of drugs on the circulation, and one that deserves more attention than it has hitherto attracted.

Henrietta-street, Cavendish-square, W.

NON-TUBERCULATED LEPROSY WITH LOCAL ASPHYXIA BETWEEN THE ANÆSTHETIC PATCHES.

BY BEAVEN RAKE, M.D. LOND.,
MEDICAL SUPERINTENDENT OF THE TRINIDAD LEPER ASYLUM.

LEPROSY, as is well known, furnishes frequent and typical examples of the various trophic lesions so often discussed in Europe. It is, however, in connexion with the more obscure condition known as local asphyxia, or Raynaud's disease, that I venture to relate this case. It is unique in my experience of leprosy, and derives additional interest from the fact of its occurring in a fair-skinned, intelligent European.

Chevy A——, aged forty-five, born in France, was admitted to the Trinidad Leper Asylum on May 19th, 1883. He had served in the Crimea and in various other parts of the world. I examined him from time to time, and was surprised to find how little progress the disease was making. Beyond localised areas of anæsthesia in the extremities, there was no evidence of leprosy. The anæsthetic skin was at this time of exactly the same colour as the unaffected skin. He was an active man, constantly employed in making boots or in work about the asylum. On returning from Europe in September, 1886, I was, however, struck by a remarkable change which had taken place during my absence. The following are the notes then taken.

Oct. 1st, 1886: The anæsthetic patches are of the normal white colour; all the rest of the skin is of a dusky red. On pressure with the finger the congestion disappears. On drawing the nail across the skin the dark colour vanishes, then reappears, and afterwards a distinct bright-red wheal is observed in the line of the finger. He says the congestion disappears when bathing in the sea. He complains of much pain in the limbs, especially in the palms of the hands. The fingers are anæsthetic, and becoming stiff.—25th: He has been trying friction with gurjun liniment, but says the fingers are stiffer and more painful. The left median nerve was therefore stretched under chloroform. The nerve was found to be thickened. Some juice was collected from the exposed nerve on a cover glass and examined with magenta, but no bacilli were found.—29th: He says there is a sleepy feeling in the palm of the hand in place of the anæsthesia. When tested with the eyes shut, he refers the impact of a substance to one side of the point actually touched.—Nov. 12th: Now that the rain is falling, the colour of the skin between the taches has turned to a dusky reddish blue. He says the fingers feel cold, and that sometimes the skin is almost black during the rains. There is now no change whatever in colour or sensation in the parts supplied by the median nerve operated on.—Feb. 14th, 1887: He has been rubbing the arms with a 10 per cent. solution of ichthyol in olive oil. The dark colour is a little lighter, but there is no change in the anæsthesia.—March 14th: The congestion of the skin is almost gone. Has had dysentery for the last month. Complains of a cold sensation in the abdomen.—April 16th: He has been losing much bright blood from the bowel lately. Is found to have a prolapse of the rectum, with congested ulcerated surface. He was given chloroform, and the lower two inches of the rectum were drawn down and everted. The mucous membrane was cauterised linearly in the long axis of the bowel with a black-hot wire. It was then rubbed over with fuming nitric acid and tannin applied.—29th: Since the operation he has passed a good deal of blood from time to time. This has been checked by injections of nitrate of silver and of opium, and by turpentine by the mouth. The violet colour between the taches on the upper extremities has gone, leaving dusky-red patches.—May 4th: Sitting up; walked yesterday. Had diarrhœa, but no more blood. To repeat turpentine.—6th: Has passed hardly any urine since last night. About four ounces of clear urine, smelling strongly of turpentine, were drawn off by catheter. Burning sensation over bladder.—18th: Has had fever every day at noon lately, which was relieved somewhat by ammonium picrate. Urine high coloured; a trace of albumen. Œdema of hands and feet. Frequent diarrhœa, but not much blood. Looks better in face.—19th: Died at 2 P.M.

The necropsy, next day, showed an enormous liver, weighing 83 oz., and containing five distinct abscesses; the total amount of pus was estimated at from two to three pints. Weight of spleen 18 oz.; simple hypertrophy. Weight of kidneys 9 oz.; cortices somewhat thinned and granular on surface. Aorta very atheromatous. No recent hæmorrhage or ulceration was found in the rectum, the ulcers appearing to be cicatrised; but the rest of the large intestine was invaded by numerous more or less circular and sharply defined ulcers. The median nerves were thickened, but no difference was found between that which had and that which had not been stretched. The right cervical sympathetic and ganglion of the vagus were dissected out, but no change was found. Sections also showed no change under the microscope. Magenta showed numerous cells in the median nerve, staining very dark, and apparently stuffed with bacilli, also some free bacilli. Numerous bacilli, both free and in cells, were found in a scraping from the superior cervical ganglion of the sympathetic.

This case revealed a mass of morbid anatomy, hardly an organ being sound. The condition of the skin, however, is the chief point of interest. The strange feature in the case is the appearance of the congestion between the taches four years after the onset of the anæsthesia. Was this due to a fresh increase of bacilli in the mixed nerves, leading to invasion of the sympathetic fibres? But if so, why is this condition not more common, for the thickened condition of the median is common enough in leprosy, as also the discovery of bacilli in the affected nerves. I thought, therefore, that possibly a dissection of the cervical sympathetic might throw some light on the matter. No naked-eye change was found, but the microscope showed numerous bacilli in a scraping from the superior cervical ganglion. This is in contrast to results obtained in the cerebro-spinal centres; I have failed to find bacilli in brain or cord, nor has their occurrence there, I believe, been recorded. The disappearance of the congestion after prolonged hæmorrhage from the bowel was a point of interest. Whether the connexion was sympathetic or more direct I cannot say. Altogether the case struck me as presenting a remarkable resemblance to the earlier stages of Raynaud's disease, and as being sufficiently obscure and rare to place on record.

Trinidad.

Clinical Notes:

MEDICAL, SURGICAL, OBSTETRICAL, AND THERAPEUTICAL.

CASE OF TRACHEOTOMY.

BY J. CRAWFORD RENTON, M.D. ED,
SURGEON TO THE EYE INFIRMARY AND TO THE DISPENSARY OF THE WESTERN INFIRMARY, GLASGOW.

THE following case presents several points of interest, and is, I think, worthy of record.

J. C——, aged seventeen months, was first seen on January 22nd, 1886, complaining of symptoms of laryngitis, with absence of the typical cough. The child had been ill for six days, the mother stated, but to-day she had observed some difficulty in breathing, which caused her some alarm. Pulse 120; temperature 101°. No cervical swelling, and no exudation on the fauces or tonsils. The usual remedies were resorted to, and were continued until January 26th, when the child had a severe spasmodic attack, with obstruction to the breathing, lasting for half an hour afterwards. Tracheotomy was advised, and in this Dr. Beatson concurred. The operation, however, was delayed, as the child

seemed slightly better. Mercurial inunction was had recourse to, as we thought it possible that some specific affection of the larynx might be causing the hoarseness and spasms. On January 31st the spasms were more frequent, and there was greater difficulty of breathing. Assisted by Dr. Beatson, I opened the trachea, with immediate relief to the urgent symptoms. There was no swelling about the throat, and no special difficulty in performing the operation. One of the late Dr. Foulis's tubes was used, and the breathing was perfect until the inner tube was inserted, when a spasm immediately took place, so that it (the inner tube) was removed. The child progressed favourably for three days, when suddenly an abscess burst into the trachea and death took place. When the nurse was dressing the child after death, she noticed something sharp and prominent at the left side of the neck, an inch below and to the outer side of the wound, and drew my attention to it. On introducing my finger into the tracheal wound, I found behind it the outline of a foreign substance, not in the trachea, but evidently between it and the œsophagus. Cutting down on the external sharp point, a pin was extracted measuring two inches in length, and from its appearance it was evident that it had belonged to a brooch or safety pin. I was allowed to examine the throat, and found that an abscess existed between the trachea and gullet, which had burst into the windpipe and caused the fatal result. The larynx and trachea were quite healthy, there being no evidence of any affection of the vocal cords.

Remarks.—On explaining the cause of death to the child's mother, she stated that three months previously, while from home, a brooch was found without the pin, which had been broken, and, like many other children, our little patient often put beads, pins, &c., into her mouth, and while in the country she may have swallowed the brooch pin. It is quite possible for a pin to remain in the œsophagus for a considerable time without causing any irritation, especially if it is fixed perpendicularly. Some displacement takes place and an abscess gradually forms, pressure on the trachea causing spasm, which in the present case necessitated tracheotomy; finally the abscess burst and displaced the pin into the position in which we found it. This case illustrates the importance of bearing in mind the possibility of foreign bodies in the larynx, trachea, and œsophagus producing spasm and difficulty of breathing, even where there is no history of such being swallowed to guide us. An examination of the larynx with the laryngoscope might have aided us, but as we felt certain that we were either dealing with an inflammatory or specific affection of the windpipe, we deemed it unnecessary to give the child chloroform for that purpose.

PARALYSIS OF THE ABDUCTORS OF THE VOCAL CORDS.

By A. Legge Roe, L.K.Q.C.P.I., L.R.C.S.I.,
RESIDENT SURGEON, HULL AND SCULCOATES DISPENSARY.

I READ with much interest the paper by Dr. Gordon Holmes in THE LANCET of the 22nd and 29th ult. During the last few weeks I have had under my care at the Hull and Sculcoates Dispensary two well-marked cases of this somewhat rare disease. The first was a man aged forty-five, who complained of marked inspiratory difficulty, which laryngoscopic examination proved to be caused by bilateral paralysis of the abductor muscles. Careful examination of the chest gave negative results. Unfortunately, being pressed for time, a complete history was not then obtained, and the man on being informed of the serious nature of the affection ceased to attend, and has been lost sight of.

The second case, a woman aged fifty-eight, is at present under treatment. She gives a most clear history of an attack of laryngitis twenty years ago, which was shortly followed by difficulty in breathing, most marked on exertion or when she had a cold. This difficulty has remained ever since. Laryngoscopic examination revealed complete paralysis of the abductor muscles; the vocal cords do not separate more than two millimetres on inspiration, and on forcible inspiration are almost driven together by the in-rushing air. Voice unaltered; sonorous inspiration present during quiet respiration, very loud during sleep. No enlarged glands, tumour, or other cause of pressure could be discovered.

This case is of interest on account of the clear history of the great length of time the paralysis has existed without calling for operative interference. The cold from which she was suffering when she first presented herself caused great inspiratory difficulty. This has now passed away, and the respiration is comparatively quiet.

Hull.

CASE OF SUPERFŒTATION.

By B. G. Godfrey, L.R.C.P., M.R.C.S.

I WAS called on Aug. 17th of the present year to Mrs. H——, aged twenty-nine, to attend her in her fourth confinement. She stated she was seven and a half months gone and had been in pain all night, with considerable loss. On examination I found a three and a half months' fœtus in the vagina, which came away without difficulty. The uterus was large, rising about two inches above the umbilicus, and I could distinctly feel the movement of another fœtus. The placenta did not come away, and all pain ceased. I then left her, as there was no hæmorrhage or pain, and returning in an hour and a half found things *in statu quo*. This state of affairs continued for four days, when the pains returned, and the breech of a child was born before my arrival. I immediately removed the child, still-born, though the nurse informed me that the legs moved after their delivery. The child must have been quite seven months, as the nails were commencing to form and its weight was 4½ lb. The placenta of the second child came away naturally, but was followed by a great deal of hæmorrhage; there was no sign of a second after-birth attached to it. Traction on the smaller cord failed to detach its placenta, so I introduced my hand into the uterus and removed it piecemeal; it was completely adherent and attached to the upper zone on the right side, measuring about 3 in. across; it was not putrid. All the bleeding immediately ceased, and my patient made an excellent recovery, without a drawback.

Balham.

DISLOCATION OF THE FIRST PHALANX OF THE INDEX-FINGER BACKWARDS.

By E. M. Harrison, M.R.C.S., &c.

A DISLOCATION similar to that recorded by Mr. Miller in a recent number of THE LANCET lately came under my observation, and may be worthy of a brief record.

A servant girl came to my surgery one morning, stating that in moving a heavy box her hand had slipped, the palmar surface of the proximal end of the phalanx coming into violent contact with the edge of the box. Since the accident, which happened about a quarter of an hour before I saw her, the finger had been immovable and very painful. There was no difficulty in recognising a backward dislocation of the first phalanx on to the metacarpal bone. This was easily reduced with the thumb of the left hand pressing on the displaced bone and traction on the finger with the right hand.

Willowmore, South Africa.

A Mirror
OF
HOSPITAL PRACTICE,
BRITISH AND FOREIGN.

Nulla autem est alia pro certo noscendi via, nisi quamplurimas et morborum et dissectionum historias, tum aliorum tum proprias collectas habere, et inter se comparare.—MORGAGNI *De Sed. et Caus. Morb.*, lib. iv. Proœmium.

ST. MARY'S HOSPITAL.

TWO CASES IN WHICH THE OPERATION FOR THE RADICAL CURE OF STRANGULATED INGUINAL HERNIA WAS PERFORMED, AN ATROPHIED TESTIS BEING REMOVED AT THE SAME TIME; RECOVERY; REMARKS.

(Under the care of Mr. EDMUND OWEN.)

THE question of excision of an atrophied testis in cases where operation for strangulated hernia is performed must be left to the discretion of the operator. By the removal of the testis and cord the canal would appear to be more effectually blocked, whilst the removal of the wasted and presumably useless organ does not add materially to the severity of the operation. The best kind of suture to be

used in approximating the pillars of the ring seems doubtful, surgeons still differing as to the advisability of using wire, catgut, or silk.

CASE 1.—R. J——, a bricklayer, aged forty-four, was admitted on May 10th, 1887. For nine years he had had a right scrotal hernia, which had been strangulated two years ago, but was reduced by taxis.

The right half of the scrotum was as big as a man's fist, and very tense; the hernia had been down for fourteen hours, and all the signs of strangulation were present. Taxis having failed, herniotomy was performed. The sac being opened, about two feet of congested small intestine were exposed; the strangulation was divided at the neck of the sac. An atrophied testis was seen at the bottom of the sac. The neck of the sac and the spermatic cord having been separately tied with strong catgut, the testis and the sac were removed together. Four strong wire sutures were then deeply passed through the pillars of the external ring and the conjoined tendon, and the inguinal canal was thus obliterated. The wound was washed with a 1 per 1000 mercuric solution, a drainage tube was introduced, and the edges of the wound were brought together with wire sutures. The patient was kept on iced water for twenty-four hours, and quarter-grain doses of morphia were administered. There were no febrile symptoms. (The epididymis was subsequently examined by the microscope for seminal filaments, but with a negative result.)

On the eighth day the wound had healed throughout, the sutures were removed, and the dressings were left off. The tube had been withdrawn at the end of twenty-four hours. Thirteen days after the operation the patient was allowed to get up, there being a large plug of dense tissue filling up the inguinal canal and surrounding the external ring. On the eighteenth day, however, some pus was detected beneath the scar; this was let out and the dressings were reapplied. On the thirty-fourth day the man was discharged. But at the end of two months he was readmitted, as some suppuration continued. The four deep sutures were therefore removed: two of them were found firmly embedded in fibrous tissue; the two others were loose. The wounds at once healed by granulation, there being a mass of hard new tissue soundly filling the canal and covering the external abdominal ring. The patient was discharged cured, and was directed not to wear a truss.

CASE 2.—F. L——, aged eighteen, was admitted Aug. 16th, 1887. His right inguinal hernia had first appeared suddenly, nine years before, whilst he was pushing a truck. He was greatly collapsed, though the bowel had been down and strangulated only three hours; taxis was unavailing. The details of the herniotomy closely resembled those of the preceding case. An atrophied testis was found in the sac; the neck of the sac and the cord were ligatured separately, and the testis and the sac were removed. The external abdominal ring and the inguinal canal were obliterated by means of sutures, which included the conjoined tendon, together with parts of the aponeurosis of the external oblique, strong chromicised gut being used instead of silver.

After twenty-four hours the tube was removed. On the seventh day the dressings were left off, as the wound had healed completely. On the eighth day the patient was allowed to sit up. On the fifteenth day he was discharged. There was abundant firm material blocking up the canal and surrounding the external ring, but it was not so plentiful as in the last case, where silver sutures had been used. About three weeks after leaving the hospital the man returned to show himself, soundly healed. There was still plenty of hard material in the canal and around the ring. The deep sutures had caused no discomfort whatever, and nothing more has been heard or seen of them.

Remarks by Mr. OWEN.—Not infrequently an atrophied testis is found associated with an inguinal hernia; often such a testis is imperfectly descended, and generally it is of more than doubtful physiological value. It might be considered a good rule to remove such an imperfect gland when operating on a strangulated hernia, as by so doing the surgeon is then enabled completely to blockade the inguinal canal. The strong silver sutures which were used (as advised by Sir Wm. Stokes) demanded subsequent disinterment, whilst those of chromicised gut in the second case served their purpose perfectly. If suppuration occurs about deep sutures, the sooner the deep sutures are removed the sooner the wound will heal.

An important point is that neither of these men was allowed to wear a truss after the operation. If the work of the surgeon has been efficiently done no truss should be wanted; if a truss be applied, its pressure hurries on the absorption of the plastic material which consolidates the weak region, and its application may thus militate against the success of the operation.

I have the pleasure of saying that the second case was operated on by my house surgeon, Mr. J. J. Clarke, whilst I acted as his assistant.

BOROUGH LUNATIC ASYLUM, PORTSMOUTH.

GENERAL PARALYSIS OF THE INSANE; ONSET IN FORM OF STUPOR; APPARENT RECOVERY; RELAPSE, WITH EXPANSIVE DELIRIUM AND SPEEDY DEATH; REMARKS.

(Under the care of Mr. J. D. MORTIMER, Assist. Med. Officer.)

MR. MORTIMER expresses his obligation to Mr. W. C. Bland, medical superintendent, for permission to publish the following notes.

W. J. A——, aged forty-four, married, boiler-maker, was admitted on Dec. 19th, 1885, with the following history. He had always been a steady hard-working man; was secretary of a trade association, and had taken an active part in a recent Parliamentary election. No family history of any neurosis. On Nov. 27th he had fallen, apparently accidentally, downstairs, striking the back of his head. On Nov. 30th, he was first noticed to have a peculiar vacant look, and began to talk and act strangely, expressing an unfounded belief that his accounts were "all wrong," turning out the gas at unseasonable times, &c. He gradually passed into the state seen on admission. He was then described as a tall, gaunt man, bald-headed, with a red beard; face sallow; expression of vacant bewilderment; pupils equal, rather sluggish; tongue slightly tremulous. No definite signs of thoracic or abdominal disease, but pulse small and weak. Totters in walking; knee jerk brisk on both sides. No special rigidity or flaccidity of muscles. When questioned, he stared stupidly, giving no response, except that, when asked if he was in pain, he said his "head was bad," and passed his hand over it. He spoke slowly, but otherwise normally.

Two days after admission it was noted that the man had slept well and fed and dressed himself (but slowly). "Sits motionless and silent, replying to questions tardily and briefly. He generally answers those as to facts correctly, but for some time persisted that the present year is 1865."

Four months after admission there had been no marked change, but he was in all respects rather worse, being more dull and confused, more vacant in look and unsteady in gait, and often "wet and dirty" in habits. From this time (April, 1886) he steadily improved, at first in bodily, then in mental condition. At the end of May he was able to work in the garden, and at the end of June he was in good general health, his pulse and gait being normal and the tremor of the tongue hardly perceptible. He conversed rationally and intelligently, the only noticeable fault being a slight slowness of mental operation.

He was discharged on a month's trial, which he spent in the country, returning apparently well in all respects. He went back to work, and for two months, according to the statements of his wife and of those under whom he served, there were no signs of relapse. He seems, however, to have fretted rather unreasonably at having lost promotion by his absence, and not to have displayed much of his former activity of mind. At the end of this period he became restless and excitable, ordering expensive articles at shops and otherwise behaving insanely. After a few days he was readmitted to the asylum on Sept. 27th, 1886. He was then very boisterous and extravagant, wanting a special train to meet the Prince of Wales, proposing to make a large fortune by raffling watches, &c. His pupils were equal, gait unsteady, knee jerk brisk, tongue slightly tremulous, and there was well-marked hesitation and thickness of speech, which had only been noticed a few days. He continued in a state of acute excitement, often violent and destructive, sleeping but little; and although eating voraciously, he grew very thin and anæmic. On Dec. 1st he had a slight attack of diarrhœa, and on the evening of the 2nd suddenly passed into a state of collapse. No treatment had any effect, and he died on the morning of Dec. 3rd, 1886.

Necropsy, twenty-four hours after death.—Calvaria of normal thickness and density. Vessels of dura mater shrunken. Sinuses contained fluid blood. Arteries at base

slightly atheromatous. Convolutions flattened and closely opposed. Pia mater tough and anæmic. Decortication well marked over anterior and outer portions of frontal lobes, slightly around fissure of Rolando, hardly perceptible elsewhere. Choroid plexuses deep violet. Much fluid at base of brain and in ventricles. Ependyma granular, especially in fourth ventricle. A small gelatinous clot in right cavities of heart; fluid blood in left auricle; left ventricle contracted. The thoracic and abdominal viscera generally showed nothing noteworthy.

Remarks.—Dr. Mickle states in his work on general paralysis, that in the few cases which set in with symptoms of stupor or pseudo-dementia, "the ordinary motor and sensory signs of general paralysis are either absent at first or are masked," appearing in most cases when the extreme mental symptoms pass off. "But not always; for a marked remission, or apparent recovery, may immediately succeed the acute symptoms, some weakness of the intellectual powers remaining." This case illustrates these statements, and perhaps also the tendency of technically "recovered" general paralytics to break down on return to their ordinary course of life.

LEICESTER INFIRMARY.

CASE OF VOMITING OF GALL-STONES; DEATH; NECROPSY; COMMUNICATION BETWEEN GALL-BLADDER AND DUODENUM; REMARKS.

(Under the care of Dr. FRANK M. POPE.)

L. H——, aged forty, married, was admitted on Sept. 3rd, 1887. Her general health had been fairly good; she had never had jaundice. Two years ago she had an attack of "pleurisy and inflammation of the bowels," and a similar attack six months ago. For the last two years she has had occasional cramping pains in the abdomen. Her present illness began five weeks ago, when during the night she had violent pain in the abdomen, worse about the right hypochondrium. The pain was unrelieved by pressure, and ease was obtained only slightly by a mustard application. The next day she began to vomit, and the pain became less violent. The vomiting has continued at frequent intervals ever since. She states that she is in the fifth month of pregnancy and has had several children.

State on admission.—The patient is a stout woman with a fresh complexion. In the right hypochondrium there is marked tenderness and a sense of resistance, but no tumour. Hepatic dulness not increased. The abdomen is slightly more tender than normally, but nothing more can be made out. There was no abnormal physical signs of heart or lungs. Urine: Sp. gr. 1010; alkaline; contains no albumen or sugar. Tongue furred thinly, and rather dry. Bowels not open for two days. Temperature 98·4°; pulse 70, feeble, regular. She was ordered a bismuth mixture every four hours, and half a grain of opium in pill at the alternate four hours. Diet to be milk, lime water, and ice.

On the day after admission she was still vomiting constantly. The vomit was green at times. No other change. On Sept. 5th, two days after admission, the note was: Last night she had a considerable increase of pain, accompanied with slight convulsions and internal strabismus. She was not unconscious. She had nutrient enemata, with half an ounce of brandy in each, every four hours. Early this morning she vomited two gall-stones of about five-eighths of an inch in diameter, with six or eight facets on each, and several smaller ones. The pain continued. She was a good deal collapsed. Temperature 97°; pulse very slow and small; bowels not open. All food and medicine by the mouth were discontinued, and she had an effervescing mixture with three minims of diluto hydrocyanic acid. On the 6th she was in much the same state, and had vomited a few more small stones. On the 7th the bowels were freely opened, and the motions contained several gall-stones, one nearly three-quarters of an inch in diameter. A few more small stones were vomited. She was taking essence of beef, and a very little milk. After this she slightly improved, the vomiting almost ceased, and she began to take a little more nourishment; but on the 17th she had another convulsive attack and subsequent collapse, from which she was revived by hypodermic injections of ether. The vomiting never entirely stopped, and on the 24th diarrhœa set in, and the nutrient enemata had to be stopped. On the 25th the temperature was 100°, the highest since admission; she was rather delirious, took little food, and the diarrhœa continued. She gradually sank and died at 7.20 A.M. on the 27th, twenty-four days after admission.

Necropsy, thirty hours after death.—Body fairly well nourished. Permission was obtained only for examination of abdomen, on opening which nothing abnormal could be seen; no general peritonitis, no excess of peritoneal fluid. Uterus reaching nearly to umbilicus. On raising the liver the gall-bladder was found to be situated in a circumscribed abscess cavity, formed by the adhesion of the neighbouring organs. The gall-bladder itself was in a sloughy condition, and several ragged openings existed at its fundus; some small stones had escaped into the cavity. There was a circular opening half an inch in diameter, with well-defined edges, leading from the gall-bladder into the duodenum, at about three-quarters of an inch below the pylorus. The common and cystic ducts were patent; one or two small stones were found in the duodenum. The stomach was healthy, and there was no ulceration from the gall-bladder into it. The rest of the abdominal organs were healthy. The total number of stones vomited weighed 170 grains; those passed per rectum 103 grains.

Remarks by Mr. POPE.—This case is interesting for the following reasons. It is an example of an exceedingly rare complication—viz., vomiting of gall-stones. Cases are mentioned by Frerichs, quoting Morgagni, Hoffmann, Portal, and Bonisson. He expresses the opinion that stones may pass from the duodenum to the stomach, but does not seem to have well considered the matter. Murchison, quoting several authors and a few cases of gall-stone vomiting, says that a gall-stone of any size could not pass backwards through the pylorus,[1] and describes a necropsy in which a direct communication existed between the gall-bladder and the stomach. The case I now report proves that Murchison's view was erroneous, and it is, I believe, the only recorded case which shows that a gall-stone may enter the duodenum and then pass backwards into the stomach. The immediate cause of death I consider to be septic absorption, which the patient was too much exhausted to resist.

Medical Societies.

ROYAL MEDICAL & CHIRURGICAL SOCIETY.

Mode of Fixation of the Scapula and Fracture of the Coracoid Process.—Some of the Surgery and Pathology of the Hip Joint.

AN ordinary meeting of this Society was held on Tuesday last, Mr. G. D. Pollock, F.R.C.S., President, in the chair.

Mr. ARBUTHNOT LANE read a paper on the Mode of Fixation of the Scapula, suggested by a Study of the Movements of that Bone in Extreme Flexion of the Shoulder Joint, and its bearing upon Fracture of the Coracoid Process. The following is an abstract of the paper:—The author showed that in extreme flexion of the shoulder joint the scapula undergoes a movement of rotation upon an axis whose general direction is obliquely inwards and forwards, and that this rotation is abruptly limited by the impact of the coracoid process upon the under surface of the clavicle. He illustrated the manner in which the frequent performance of this movement under the influence of considerable strain determines in such labourers the development of a coraco-clavicular articulation, the mechanism of which he had already described in the Guy's Hospital Reports, 1886. He then referred to the very great difficulty which is usually experienced in breaking down adhesions between the humerus or scapula, these adhesions being in most cases the result of inflammation. The difficulty arose from the inability to fix the scapula. He showed that the scapula can be firmly fixed by flexing the shoulder joint completely, the coracoid process and clavicle being held forcibly in apposition, and that when the scapula is so fixed against the clavicle the humerus can be rotated forcibly upon its own axis, and can be completely adducted and then abducted very considerably without the humerus being accompanied in its movements by the scapula. In this manner all adhesions between the two bones can be readily

[1] The exact statement of Murchison reads: "The possibility, indeed, of a large calculus passing backwards through the pylorus is very doubtful." Murchison: Diseases of the Liver, 2nd edit., p. 494.—ED. L.

broken down. He then criticised the statements made by surgical writers that the coracoid process is always broken by direct violence, and referred to two cases quoted by the author of the article on Fractures of the Upper Extremity in Holmes's System to prove the truth of the above assertion, which, he said, showed that the very reverse was true in this case, for the reason that when the shoulder joint is completely flexed it is practically impossible to fracture the coracoid process by direct violence. He also referred to the extreme inaccuracy of published statistics of the relative frequency of fractures of the several bones, and particularly of the coracoid process and acromion. He had never found a single instance of fracture of the coracoid process in the dissecting room, but he had observed that fracture of the acromion occurred more frequently than fracture of any other bone in the body.—Mr. W. ADAMS agreed with the anatomical and physiological conclusions of the author, but he could not concur with the surgical conclusions, for in an ankylosed joint it would not be possible for the joint to be flexed. The difficulty of fixing the scapula was not great. He had never found any difficulty himself in fixing the joint firmly. There often appeared to be plenty of movement, but this was of the scapula, and not really in the joint. In a few difficult cases the ankylosis could not be broken down, and he should recommend that such cases be left alone.—Mr. CLEMENT LUCAS said it was new to him that the coracoid process could be fractured in the way Mr. Lane had described, and the explanation was very easy to understand. He agreed that fracture of the acromion process was more frequent than was commonly supposed. Attempts at flexion of the shoulder would inevitably bring the coracoid process into contact with the clavicle, and so afford the necessary *point d'appui*.—Mr. HOWARD MARSH thought the explanation of fracture of the coracoid as likely to be the true one. He considered that the difficulties of fixing the shoulder joint were not so great as the author had inferred. In breaking down adhesions the use of anæsthetics was most desirable. If the joint be really fixed as determined under anæsthesia, he should advise that the case be left alone, for any temporary improvement was most likely to be followed by increased ankylosis and increase of the joint disease. The acromion may be apparently detached by the chronic rheumatic joint disease.—Mr. LANE, in reply, considered that the changes in the acromion were more frequently due to injury than to a rheumatic process.

Mr. ARBUTHNOT LANE also contributed a paper on an undescribed method by which the Superjacent Weight of the Body is transmitted in a United or Ununited Fracture of the Neck of the Femur through an acquired Ilio-femoral Articulation, and the bearing of the principle involved upon the Surgery of the Hip Joint. The following is an abstract:—In the examination of 320 bodies the author of the paper had found several instances of fracture of the neck of the femur, of which three were ununited and the remainder united. In three out of the small number of these fractures observed, he found that a large proportion of the superjacent weight of the trunk was transmitted to the femur through a new joint which had formed between a strong, dense mass of bone, which projected upwards and inwards from the anterior inter-trochanteric line and the neighbouring portion of the femur and the ilium, immediately beneath its anterior inferior spinous process. The only attribute which was common to these three cases was a veryconsiderable displacement of the head of the femur downwards, which so altered the direction of its articular surface as to render it more or less useless for its original purpose. The most interesting of the three cases was an ununited fracture of the neck of the femur, for in it the whole or almost the whole of the superjacent weight of the body was transmitted through the ilio-femoral articulation which had developed between the callus projecting from the front of the neck of the femur and the anterior inferior spine. He thought that the mechanical principle illustrated by these three specimens, and especially by the ununited fracture, might be applied very happily to the surgery of the hip joint. He referred to the very unsatisfactory results of excision of the hip joint, and showed that, besides the shortening of the limb, the extreme insecurity of the joint resulting from the operation was the cause of its practical failure. If the upper extremity of the femur could be displaced inwards and could be connected to the innominate bone so as to form a new joint similar or identical in character with that which had developed in the three cases of fracture described in this paper, a very useful limb would be obtained, and one that would readily transmit the weight of the body without the assistance of any support, and permit of compensation of the shortening. The difficulties which would be experienced in fixing and retaining the femur in position might in some cases be very great, but not greater than our present facilities of operative treatment would enable us to meet. He also appended to the paper diagrams with short descriptions illustrating the conditions which are usually presented by united and ununited fractures of the femur.—Mr. G. D. POLLOCK asked whether the united fractures of the femur were impacted in some cases or in all.—Mr. A. E. BARKER spoke of excision of the hip joint, and thought that in early cases, where extensive destruction had not taken place, good results might be expected and obtained. He had had cases in which excision was very successful. The incision made by Mr. MacEwen did not divide the capsular muscles at all, nor were any nerves or vessels divided. With this method very satisfactory results were obtained, and the head of the femur rested on the ilium, in the position indicated by Mr. Lane as so favourable after fracture. He thought that Mr. Lane's suggestion would prove a valuable one.—Mr. PICKERING PICK referred to the outgrowth of the buttress of bone from the fractured femur as affording a support through which the weight of the body could be transmitted. Nevertheless, as in a case mentioned, a fracture united by thick fibrous capsule could form an efficient support for the weight of the body.—Mr. WARRINGTON HAWARD considered that in excision of the hip joint there was an essential difference from the conditions that obtained in Mr. Lane's specimen, for in a fracture the head of the bone remained in the acetabulum, whereas in disease of the joint the head of the femur was often dislocated and even removed. In cases of successful excision, in spite of the great shortening, good union and power might result.—Mr. HOWARD MARSH agreed that the operation of excision of the joint was very different now to what it formerly was. Absolutely unjustifiable was it to turn the head of the femur out of a large wound and saw off a large portion of the bone. He usually performed the operation now by an incision through the muscles on the back of the joint, and sawing off merely the head of the bone. The anterior incision might be suitable for the procedure suggested by Mr. Lane, and there ought to be but little difficulty in forming a joint between the head and the ilium.—Mr. BARWELL asked in what proportion of cases the buttresses of bone were found on the femur.—Mr. LANE, in reply, said that in most of the cases the united fractures were impacted; he could not state from memory the proportion of cases with buttresses.

MEDICAL SOCIETY OF LONDON.

Acute Glossitis in a Child.—The Presystolic Murmur.

A MEETING of this Society was held on Monday, Nov. 7th, Dr. J. Hughlings Jackson, F.R.S., President, in the chair.

Mr. MARMADUKE SHEILD read notes of a case of Acute Glossitis in a child, aged six years, complicated by trismus. On its admission into Charing-cross Hospital on the 7th of September, it was noted that the tongue protruded from the mouth, and was enormously swollen. The jaws had closed upon it, and the teeth had ulcerated deeply into the organ, which seemed on the verge of sloughing. The child was quite unable to swallow, and there seemed danger of death from dyspnœa or starvation. The mother stated that the symptoms had come on quite suddenly after an attack of "quinsy." Under chloroform the jaws were opened with a gag, and the tongue freely incised. Free hæmorrhage occurred, and the tongue was rapidly reduced in size. It, however, remained hanging out of the mouth in a paralysed state for upwards of fourteen days. The tetanic contraction of the jaws was marked, and was overcome by the constant wearing of a gag. This was attributed to reflex irritation through the lingual branch of the fifth nerve, and the paralysis of the tongue to a combination of diffuse inflammation of its muscular substance with want of effort to retract it on the part of the child. Ultimately the case recovered perfectly. The efficacy of incisions in acute glossitis was exemplified and dwelt upon, and importance was attached to the possibility of error in the diagnosis of a deeply seated abscess of the tongue simulating glossitis. The best and safest manner of incising the different parts of the tongue was briefly touched upon.—Mr. JAMES BLACK pointed out the danger the lingual artery ran of being wounded in incising some cases of glossitis.—Dr. SIDNEY

PHILLIPS quoted cases which showed that glossitis and post-pharyngeal abscess followed exposure to foul emanations.—Dr. ANGEL MONEY maintained that the motor portion of the fifth, if not weaker than other nerves, responded much more readily to irritation.

Dr. BRISTOWE read a paper on the Presystolic Murmur, a full report of which will be found in another part of our present issue.—Dr. DICKINSON was glad to find that Dr. Bristowe recognised the murmur described by Hope. He thought it very nearly resembled the aortic diastolic bruit, from which, however, it might be diagnosed by change of posture, the mitral being heard best with the patient lying down, the aortic when standing up. The so-called presystolic bruit was accompanied by a thrill and an impulse which he maintained was due to ventricular systole. In the usual explanation the systole was represented merely by a "snap" at the end of the bruit, whereas he held that the rolling murmur ending with a snap all occurred during ventricular contraction. He explained the "mixed murmurs" (combined presystolic and systolic) by supposing a primary regurgitation through the stiffened valve segments, followed by imperfect closure with continued reflux. He could not conceive how the blood could flow in one direction and then the current should be suddenly reversed without a corresponding break or pause in the murmur.—Dr. SANSOM regarded the murmur as undoubtedly presystolic, though he differed from Dr. Gairdner as to its mode of production. He did not think it was coincident with auricular systole; it often occurred immediately after the second sound. The cause of the reflux of blood into the ventricle was the tension in the left auricle and pulmonary veins caused by the forcible action of the right heart. The snap was caused by the coming together of the flaps of the tricuspid valve. Cardiographic tracings failed to show a proportionately larger systole in mitral stenosis, which according to Dr. Dickinson's hypothesis ought to be the case.—Dr. BURNEY YEO had observed the auricular contractions in a phthisical patient, with retracted left lung; and the harsh presystolic murmur was exactly synchronous with them. There was a distinct interval between the beginning of the murmur and the carotid pulse.—Dr. BROADBENT knew of cases in which there was perfect continuity between the mitral diastolic and the presystolic murmur. He had seen one murmur grow out of the other: the presystolic from being short and running up to the first sound had been, so to speak, prolonged backwards till it began with the reduplicated second sound, and eventually it might even develop into a mitral diastolic only. Dr. Dickinson had said that the snap at one time ended the systole, and at another occurred in the middle of it. With this he could not agree. He declined to accept Dr. Sansom's theory of the causation of the snap because the right ventricle was in the same condition in mitral regurgitation, but then no snap was heard.—Sir DYCE DUCKWORTH said that if the murmur were really systolic it ought to be conveyed to the lower angle of the scapula.—Dr. KINGSTON FOWLER showed a boy of eighteen with double mitral murmur and tricuspid regurgitation. The snap was present despite the tricuspid incompetency. That stenosed mitral valves were in many cases capable of closure was proved by their "facetted" appearance post mortem.—Dr. STEPHEN MACKENZIE had seen a case with well-marked presystolic bruit, in which at the necropsy the flaps presented a roughened auricular surface, but were competent. He referred to Dr. Hilton Fagge's objection: that, if these cases were really due to incompetence, dilatation of the left ventricle should follow.—Dr. BRISTOWE, in reply, confirmed Dr. Broadbent's statement, that the right ventricle was dilated and hypertrophied in aortic regurgitation.

OBSTETRICAL SOCIETY OF LONDON.

A MEETING of this Society was held on Wednesday, Nov. 2nd, G. E. Herman, M.B., Vice-President, in the chair.

Mr. BLUETT showed a Hydrocephalic Fœtus. The circumference of the head was twenty-seven inches and a quarter.

Dr. W. S. GRIFFITH exhibited a specimen of Hæmatometra and Hæmatosalpinx, in which a clot was seen extending from the body of the uterus through the Fallopian tubes, and projecting a couple of inches from the fimbriated extremity of one of them. Also a case of Pyometra, which illustrated occlusion of the cervix by pressure of a fibroid. Both these specimens were from St. Bartholomew's Hospital museum.

The PRESIDENT gave notice that a special meeting of the Society would be held on Nov. 23rd, commencing at 8 P.M., for the discussion of the subject of Extra-uterine Fœtation.

Vaginal Tumour.—Mr. GEORGE LOWE described a case in which, during a difficult and painful menstrual period of a girl aged fourteen, a painless tumour the size of a pheasant's egg formed in the left vaginal wall. This proved to be connected with a large tumour filling the pelvis and extending up to the umbilicus. There were no symptoms of constitutional disturbance. On vaginal exploration no cervix could be found, but a small depression high up posteriorly admitted a catheter for two inches. On puncture of the vaginal tumour a dark treacle-like inodorous fluid escaped. The discharge ceased. All swelling disappeared, and the patient recovered.—Mr. HERMAN thought the case was extremely like one of unilateral hæmatocolpos—i.e., double uterus and vagina, one vagina being imperforate, and the secretion of the corresponding uterus accumulating in it, while the patient menstruated through the other. Owing to the relations and characters of the parts being altered by distension, diagnosis was difficult in these cases.

Hydrocephalus as a Complication of Labour.—Dr. J. W. SWAYNE, after pointing out the rarity and dangerous nature of this complication, gave the particulars of seven cases occurring in his own practice, in three of which delivery took place spontaneously, and four required the assistance of art. In one of the former the mother died apparently from rupture of the uterus. This accident proved fatal in rather more than a fifth of the cases collected by Dr. Keith, the cause being the great stretching of the lower segment of the uterus, and the difficulty thus occasioned to the process of retraction over the head. Dr. Swayne laid great stress on an early diagnosis of this complication, and on the extreme danger of an expectant treatment, and pointed out the great importance of reducing the size of the child's head by puncture as soon as a correct diagnosis had been formed. He related cases showing the disastrous results which have arisen from delay or from attempted delivery with the forceps, owing to mistaken desire to save the life of the child.—Dr. GERVIS wished to emphasise the importance of the method of examination by inserting the hand into the vagina so as to make sure of the presence of hydrocephalus before proceeding to operate. He had met with cases of severe injury to the vagina from the forcible delivery of hydrocephalic heads, the condition not having been recognised.—Dr. BRAXTON HICKS advocated the introduction of the whole hand into the vagina for the sake of diagnosis, not only in cases of hydrocephalus, but in all cases of ambiguity, so as to see exactly the want of relation between the head and brim.—Dr. GALABIN mentioned a case which he had lately seen. The diagnosis was difficult, owing to the slight development of the cranial bones and a comparative absence of hair on the scalp. The bimanual method, with the introduction of the whole hand into the vagina, easily revealed the large size of the head. In moderate degrees of hydrocephalus in which the bones were highly developed and the sutures widened, he had found the nature of the case revealed by the blades of the forceps being widely apart when applied and easily slipping off.—Dr. PLAYFAIR said that, while he fully endorsed all that had been said as to the importance of the subject of the paper, he must take exception to the statement that it had been insufficiently treated in modern text-books. In his own work it had been fully considered, and he had pointed out the precise dangers and advocated the same rules of treatment as the author of the paper. Suspicions of intra-uterine hydrocephalus might be aroused by the peculiarly violent, almost tetanic, pains which result from the vain efforts of the uterus to make the presenting head engage the pelvis. When from the experience of former labours or actual measurement the dimensions of the pelvis are known to be normal, and the head refuses to enter the brim in spite of violent pains, the patient should be thoroughly anæsthetised and a complete exploration made with the hand in the vagina. This would certainly lead to a recognition of the difficulty, and possibly to the prevention of disaster by early puncture of the head.—Dr. BOXALL thought that in certain cases podalic version was advisable after evacuation of the fluid, though in the majority of cases it was unnecessary. In cases like that which Mr. Bluett had shown, the head was enormously dis-

tended, and the bones at the vault widely separated. If the base of the skull is brought down first, the bones of the vertex will fold together like a parachute.—Mr. JOHN PHILLIPS had met with two cases of hydrocephalus, one presented by the head, the other by the breech. The former was complicated by hydramnios. The diagnosis was easy after rupture of the membranes, and perforation was followed by an easy labour. He found that 7·5 per cent. of the total cases of hydrocephalus were complicated by hydramnios. In difficult cases, when the breech presents, he thought that the plan recommended by Tarnier, to cut into the spinal column as near the neck as possible and draw off the fluid by means of a catheter, was a good one.—Dr. GRIFFITHS stated that it would conduce to the certain determination of the cause of frequent presentation of the breech in cases of hydrocephalus if those who met with them would take the specific gravity of the hydrocephalic fluid. The specific gravity of the fœtus was stated to be 1055, and of the liquor amnii 1010 to 1015, while that of the fluid which was drawn from the head of the fœtus shown by Mr. Bluett was 1010. This difference would amply account for the floating of the head to the top of the amniotic fluid, especially early, when the fœtus is mobile in the uterus. If the disease attacked the head when it was less movable in the uterus, the head, naturally dependent, might remain so.—Mr. HERMAN spoke of the value of external palpation. By this means he thought it was easy to identify the head, and roughly judge of its size. A German writer, Brühl, had directed attention to what he called "Eindruckbarkeit" of the fœtal head—i.e., the extent to which it could be pressed down into the pelvis with the hands, and he (Mr. Herman) believed this measure was of service in forming a prognosis as to the ease or difficulty of labour. If applied in cases such as those under discussion the presence of a condition entailing difficult or impossible delivery would be at once recognised.

A Case of Hæmatometra associated with a degenerating Fibro-myoma, treated by Supra-vaginal Hysterectomy, was related by Mr. W. A. MEREDITH. The patient, aged forty-six, had been subject to a large abdominal tumour for many years. In April, 1883, the patient, who had up to that date suffered from severe menorrhagia, was seized with pleurisy, and was confined to bed for eight weeks. Menstruation ceased from that date. She suffered from abdominal tenderness and severe attacks of spasmodic pain in the tumour, till she was admitted into the Samaritan Hospital in December, 1886. The abdomen was then occupied by an enormous semi-solid growth, which was diagnosed as a uterine fibro-cyst. The vaginal portion of the cervix uteri was soft and unenlarged; its canal was occluded. The tumour, with both ovaries and tubes, was removed by supra-vaginal hysterectomy on Dec. 17th, 1886, and the patient returned home quite well six weeks later. The tumour consisted of an enormously distended uterus, with a degenerating fibroid in its anterior wall. A cavity in this growth communicated by a large oval aperture with the uterine cavity, both were filled with altered blood. The posterior wall of the uterus was greatly hypertrophied. The entire mass weighed 15 lb., and must originally have contained at least 5 lb. of blood. The complete and persistent retention arose from some cause effecting sudden occlusion of the cervical canal, probably inflammatory in its origin, and rendered permanent by partial rotation of the elongated uterine cervix during the patient's confinement in bed in 1883. The specimen demonstrates a somewhat rare incident in the life history of uterine tumours.—Dr. GALABIN thought that one of the points of interest in Mr. Meredith's case was the bearing of such on the question of uterine distension with either blood, pus, or mucus without absolute obliteration of the cervical canal. The rule was that in actual stenosis of the canal the uterus became hypertrophied to overcome the obstruction, and was not dilated. He had met with exceptions to this rule. In one instance pyometra in an old woman was the result of retroflexion, and was cured by emptying frequently by digital pressure.—Dr. GERVIS had seen many cases of dysmenorrhœa in cases of fibroid uterus connected with more or less stenosis of the cervix, but no case of actual atresia. In a case of large interstitial fibroid which he removed by supra-vaginal hysterectomy last year, the interior of the tumour was found to be in a state of necrosis, and he would like to know if Mr. Meredith had often found this condition in fibroids, and whether there were any symptoms indicative of its occurrence. In Dr. Gervis's case there had been none.—Mr. HERMAN said that we ought not to base conclusions as to the effect of obstruction to the exit of fluid from the uterus on inferences drawn from cases like the present one. The question as to the effect of flexion was one of fact to be settled by observation. Some said that dilatation of the uterus was the result, others said there was hypertrophy, but no specimens existed that showed either dilatation or hypertrophy, cases in which the uterus was fixed or which had undergone senile atrophy being excepted.—Dr. HORROCKS thought the case threw light on some cases of fibro-myomata in which, years after the climacteric, uterine hæmorrhages occurred. He suggested that the hæmatometra might be due to breaking down of the tumour which opened into the uterine cavity.—Mr. MEREDITH replied.

MIDLAND MEDICAL SOCIETY.

A MEETING of this Society was held on Oct. 19th, Mr. Lawson Tait, F.R.C.S., in the chair.

Odontoma.—Mr. JORDAN LLOYD exhibited a rare specimen of odontoma, removed from the upper jaw of a man nineteen years of age. It measured 1¼ in. long, 1½ in. across, and 1 in. deep, and weighed 247 grains. The specimen is probably unique, as no such case can be found previously recorded. The tumour had been diagnosed "necrosis" prior to removal. On section it showed most characteristically the arrangements in irregular lamellæ of dentine and other dental tissues. The mass was lifted out of its bed with an elevator. The tumour occupied the site of the second and third upper right molars.

Rodent Ulcer.—Mr. EALES showed a man, aged seventy-three, on whom he had operated, removing the upper and lower eyelids, eyeball, and orbital contents on the left side, for rodent ulcer of eight years' duration, which had involved the lids and commissures, together with the conjunctiva and cornea of the left eye, freely. The specimen was also shown, together with microscopic sections of the same, which exhibited the characteristics of rodent ulcer.

Raynaud's Disease.—Dr. SUCKLING showed a strumous-looking girl, aged twelve, who was suffering from symmetrical gangrene of the fingers and toes. When two years old she was bitten by a rabbit on the right forefinger, and three months after this the fingers began to be blistered, and since that time she has never been free for a month, always having a sore finger or toe. She suffers from paroxysmal attacks of inflammation in the fingers, accompanied with severe pain. The terminal phalanges with the distal half of the middle phalanges are lost in the fore, ring, and little fingers of both hands, the fingers being swollen, red, and ulcerated at their extremities. The thumb is inflamed and the terminal phalanx is necrosed. There is no anæsthesia and no pain. The skin of the legs is bluish and thin, and ulcerated in several places, the slightest injury causing an intractable ulcer. The terminal phalanx of each little toe has been necrosed. The knee-jerk is present; the plantar reflex lost. The condition of the extremities is always worse in cold weather. There is no history of struma in the family, but the girl herself is weakly and ill-nourished.

Ulcerative Endocarditis, with Congenital Malformation of the Heart.—Dr. SUCKLING also showed the heart of a girl, aged sixteen, in whom during life he had diagnosed ulcerative endocarditis. She was admitted into the workhouse infirmary seven weeks previously to her death, and on admission was found to be very anæmic and thin, with pyrexia of a markedly remittent nature, reaching 102° to 104°F. at night, and falling to normal in the morning, with profuse sweats. A loud systolic bruit was present over the pulmonary area, and the spleen was slightly enlarged. At the necropsy stenosis of the pulmonary orifice was found, with an incomplete ventricular septum. The left ventricle was dilated, and extensive ulceration was present at the apex, the wall being very thin in this situation. The right ventricle was hypertrophied; infarctions were present in the kidneys, and the spleen was large and very soft. The presence in this case of the pulmonary systolic bruits, though not due to ulcerative endocarditis, enabled this diagnosis to be made, for without the murmur this would have been very difficult, if not impossible.

Plum-stone impacted in Bronchus.—Dr. SIMON showed a plum-stone that had been impacted in the right bronchus of a boy aged six. On opening the trachea the stone was at once coughed out.

Suppurating Ovarian Tumour.—Mr. LAWSON TAIT showed a suppurating ovarian tumour that he had recently successfully removed.

Ovarian Cysts.—Dr. MALINS showed two pedunculated

ovarian cysts that he had successfully removed from a patient aged fifty-six.

Dr. MALINS read a paper on Varicose Veins in the Broad Ligament.

The following office-bearers have been elected for the ensuing session:—President: Mr. Ross Jordan. Ex-President: Mr. Lloyd Owen. Treasurer: Mr. Garner. Members of Council: Dr. Savage, Dr. Simon, Mr. Eales, Mr. Ker, Mr. Chavasse, Mr. Priestley Smith, Mr. Wm. Thomas, Mr. A. Clay, Mr. Bennett May, Mr. Jordan Lloyd, Mr. Messiter, and Mr. Harmar. Secretaries: Dr. Suckling and Mr. Haslam.

Reviews and Notices of Books.

A Course of Elementary Practical Histology. By WILLIAM FEARNLEY. London: Macmillan and Co. 1887.

THIS book, which forms one of the excellent series of manuals for students, differs from other text-books of practical histology in many respects. It gives a complete list of the necessary apparatus, a new classification of the structures required, and much fuller detail in the various methods of preparation and mounting than is to be found elsewhere. Every process laid down in the work has been personally tested, and the course is a most thorough and complete one, and can be carried out even without the aid of a teacher, although of course not so satisfactorily and readily as if he were present. Mr. Fearnley begins at the beginning by describing what kind of a room should be chosen for a private histological laboratory, and then urges the necessity of an index of its drawers and shelves, and a diary for the details of the daily work. A good description of the microscope and of the necessary apparatus for measuring, drawing, and photographing objects then follows; and the next chapter is devoted to reagents and minor operations, such as cleaning cover-slips and slides, ringing slides, cell-making, &c. Teasing; irrigating; applying gases, vapours, and heat; injecting; dissecting; hardening and softening; embedding; section-cutting; staining; dehydrating and clearing; and mounting, follow in due order, and are most methodically and minutely described. The amount of detailed description given by the author can only be appreciated by those conversant with the book and the processes referred to. A list of the materials to be collected, and of the animals from which they can be most readily obtained, and how they should be prepared, completes the first part of the book, and to this part no words of commendation can be too strongly applied. The second part also, so far as concerns the arrangement for filling in the particulars respecting any preparation, is suitable enough; but the paragraphs relating to the definition of terms are quite out of place, and unnecessarily increase the size of the book. Writing out definitions from Quain, Klein, Schäfer, and Purser is a tedious task; it has nothing whatever to do with practical histology, and the book would be the better for the omission of the space alloted page after page to this defining of terms. Considering that Mr. Fearnley is engaged in general medical practice, it is certainly most creditable to him that he should have found time to work out the various processes and methods, and to describe them so admirably and with such praiseworthy detail. In another edition we would suggest that if a reference to pages as well as to paragraphs were given, it would be a further improvement.

A Treatise on the Animal Alkaloids; or the Ptomaines and Leucomaines Chemically, Physiologically, and Pathologically considered in relation to Scientific Medicine. By A. M. BROWN, M.D. With an Introduction by Professor ARMAND GAUTIER. Pp. 182. London: Baillière, Tindall, and Cox. 1887.

THIS is a very unequal book. The avowed intention of the author is to submit to the scientific student in England an introduction to the study of the animal alkaloids, and it is frankly admitted that the task would have been impossible without the encouragement and aid of continental workers in this department. From the introduction by M. Armand Gautier we realise the magnitude of the task undertaken—viz., "to give a stimulus to investigations new and fruitful in the elucidation of a question the most essentially humane—the cause and mechanism of life, health, and disease." The existence of ptomaines and leucomaines, and their deleterious actions, have only been brought into prominence within recent years, and it may still be doubted whether their composition and their effects have been sufficiently worked out to lead to any very practical result beyond establishing a word of warning for medico-legal experts engaged in investigating cases of supposed criminal poisoning. Some of the chemical terms appear in a form which may send scientific investigators to the original text for information. As examples, it may be sufficient to point to the frequent recurrence of "sulphurated" and "phosphorated hydrogen," "anhydrid carbonic," and "alcohol absolute." The work is divided into three sections, dealing respectively with the cadaveric alkaloids or ptomaines, the vital alkaloids or leucomaines, and the relation of the vital or physiological alkaloids, the leucomaines, to scientific medicine. The first two sections, although they give numerous classifications and definitions, are far from satisfying. Oversights occur in the revision of the proofs; for instance, on page 40, in consecutive lines we find "Schmiedelberg" and "Schmiedberg." In the third section, however, a notable improvement occurs, both in the correctness of technical terms and in smoothness of diction, and here we glean the author's own views, which are certainly of a controversial character. Stated briefly, they assert a belief in the revival of the doctrine of "humoralism" as the basis of rational medicine. "What M. Gautier has been showing, and shows so admirably, is simply that the school of the past and the school of the future will be found to mutually support each other, and further, that humoralism, if you will, so far from being vanquished, has been only stolidly refurbishing its arms and reinspecting its resources; whilst pangermism has been exhausting its energies in sensational demonstrations of bacterial surprises and bacillar blunderings." The pages in which these views are elaborated are full of interest, although we feel disposed to take leave of the book with the author's concluding words: "Let us wait for a little, and we shall see more."

OUR LIBRARY TABLE.

Middlesex Hospital Reports.—The annual report of the cases treated in this hospital for the year 1885 presents the general features which have distinguished its predecessors, but a few changes have been made with the intention of diminishing its size and cost of production. The general table of diseases has been prepared as in previous years, but with this exception all tabular matter has been excluded. Dr. Pasteur, who is responsible for the report of the medical department, gives a general synopsis of the cases of enteric fever, a summary of each case of malignant disease treated in the medical wards for the year, and a detailed account of some instructive cases under the heading "Selected Cases of Unusual Interest." In the report of the surgical department Mr. Roger Williams adds to the number of cases of cancer which have been fully analysed from 1882 (making over 800), and his general report is exhaustive and complete. The third part of the volume is occupied by the pathological report of Dr. Kingston Fowler, and contains a brief record of 283 post-mortem examinations of medical and surgical cases. These records are not merely of interest in themselves, but are important for future reference. It would be a good thing if our metropolitan hospital reports were

more available for reference and the plan adopted more uniform.

The Quarterly Journal of Microscopical Science. Edited by Professors RAY LANKESTER, THISELTON DYER, E. KLEIN, H. MOSELEY, and ADAM SEDGWICK. New Series, No. 109, Vol. XXVIII., Part 1. London: J. and A. Churchill.—This part contains the following memoirs:—1. The Anatomy of the Madreporaria, Part 3, by G. H. Fowler, with Plates 1 and 2. 2. On the Anatomy of Mussa and Euphyllia, and on the Morphology of the Madreporian Skeleton, by H. C. Bourne, with Plates 3 and 4. 3. On the Intra-ovarian Egg of some Osseous Fishes, by Robert Scharff, with Plate 5. 4. Observations on the Structure and Distribution of Striped and Unstriped Muscle in the Animal Kingdom, and a Theory of Muscular Contraction, by C. F. Marshall, with Plate 6. 5. On the Fate of the Muscle-plate, and the Development of the Spinal Nerves and Limb Plexuses in Birds and Mammals, by A. M. Paterson, with Plates 7 and 8. 6. Note on the Ciliated Pit of Ascidians and its relation to the Nerve Ganglion, and the so-called Hypo-physial Gland, and an account of the Anatomy of Cynthia Rustica (?), by L. Sheldon, with Plates 9 and 10. 7. The Tongue and Gustatory Organs of Mephitis Mephitica, by Frederic Tuckerman, with Plate 11. 8. On the Quadrate in Mammalia, by Dr. G. B[illegible]. 9. On the Hæmoglobin Crystals of Rodent's Blood, by W. D. Halliburton. 10. An Easy Method of obtaining Methæmoglobin Crystals for Microscopic Examination, by W. D. Halliburton.

The Journal of Physiology. Edited by MICHAEL FOSTER. Vol. VIII., Nos. 3 and 4. August, 1887. Cambridge: Cambridge Scientific Instruments Company's Works.—The following contributions are contained in this part. 1. Phillips and Bradford on the Action of certain Drugs on the Circulation and Secretion of the Kidney; Plates 4 and 5. 2. W. D. Halliburton on Muscle Plasma. 3. H. Sewall: Experiments on the Preventive Inoculation of Rattlesnake Venom. 4. A. Haig: Variations in the Excretion of Uric Acid produced by administration of Acids and Alkalies; Plate 6, Figs. 1 to 3. 5. I. Ott and C. Collmar: Pyrexial agents—Albumen, Peptone, and Neurin; Plate 6, Figs. 4 and 5.

A Manual of Physiology. By GERALD YEO, M.D., Professor of Physiology in King's College. Second Edition. Pp. 668. London: J. and A. Churchill. 1887.—We are glad to see a second edition of this excellent manual. Professor Yeo is engaged in teaching, and therefore well knows what is required by the student. The work contains a considerable amount of histology, and is illustrated by many woodcuts. The purely physiological part is thoroughly worked up to the knowledge of the present day.

Conversation Lessons on Prompt Aid to the Injured. By HENRY WEBB. With 47 Illustrations. Pp. 122. Bury: W. S. Barlow. 1887.—*First Aid to the Injured: the Ambulance Pupil.* By a PUPIL of the St. John Ambulance Association. Pp. 46. London: Crosby Lockwood and Co. 1887.—We are by no means sure that the form of question and answer adopted in the first-named of these books is the best adapted for imparting instruction. It would appear, however, that the men attending the ambulance lectures delivered at Bury by Mr. Webb represented to him that they would understand and remember them better if the text-books were arranged in that form, and especially in view of the examination which followed. In compliance with the wish thus expressed Mr. Webb prepared the present handbook, which appears to have been carefully compiled, and will doubtless prove useful not only to the persons for whose instruction it was intended, but also to those on whom the examination of ambulance classes may devolve. The book has the advantage of a copious index. "The Ambulance Pupil" is another addition to ambulance literature. The instructions are given plainly and concisely. The book is of a portable size and form, and seems well adapted to the use of the class for whom it is intended. Like the one just noticed, it has a good index. In the directions for the treatment of "alcoholic poisoning" (drunkenness) we miss a very necessary caution against placing the patient on his back—a position which, if he became sick, would be very liable to give rise to suffocation.

Wintering Abroad. By Dr. ALFRED DRYSDALE. Second Edition. Pp. 63. London: Virtue and Co. 1887.—The object of this work appears to be to recommend the Riviera in preference to all other places as a winter residence for invalids, and Mentone as the best of all the winter stations. We cannot say that it adds anything to our knowledge on these subjects. The very brief notices of "the different winter stations for the benefit of those who are wholly ignorant of the subject" can scarcely be of much use in aiding them to form an opinion as to the most suitable winter residence.

Health Maps. A complete series of prescribed Exercises of the Body for daily use for maintaining the Health in a state of integrity, for correcting any tendencies to Functional Irregularity, and for resisting the Encroachments of Disease. By ANNA L. ARNIM. Five Groups. London: Swan Sonnenschein, Lowrey, and Co. 1887.—In the introduction to the maps the authoress says: "There is an intermediate state of health, which is far more common than is supposed, and which may best be designated by the term 'negative health.' It is a condition in which one can neither lay claim to being actually ill, nor assert with truth that one is 'quite well.' .....It is to minimise the chances of break-downs, to keep at bay this negative, and perpetuate the positive state of health that is the object of these maps." Without endorsing all that is said respecting the special application of the different groups of exercises, we may say that the figures show very clearly, by means of dotted lines, the manner in which the various exercises are to be performed. The Health Maps would, in our opinion, prove very useful to those entrusted with the care and education of children, by showing how a course of useful calisthenics may be efficiently carried out without the aid of any apparatus.

Modern Gymnastics (Elementary). By A. ALEXANDER. Containing over 200 Illustrations by G. RUSHFORTH. Pp. 140. London: Philip and Son. 1887.—This work is intended as a guide to the members of the National Physical Recreation Society who cannot avail themselves of professional teaching. It consists of a series of gymnastic exercises to be performed with the usual appliances to be found in a gymnasium. The words of command for the instructor and the directions for the pupil are given for each movement, with an illustration showing the position of the pupil, and a musical accompaniment, deemed, we presume, appropriate to each exercise. We are disposed to think that some of the more advanced exercises, especially with the double bar-bells, the clubs, the bars, and the trapeze, ought not to be undertaken by delicate persons except under medical advice and careful supervision, and in all cases care must be taken not to attempt too much or to continue the exercises too long at a time.

The Physicians and Surgeons' Visiting List, Diary, Almanack, and Book of Engagements for 1888. John Smith and Co., London.—This Visiting List is now entering upon its forty-second year of successful publication, a proof that it is appreciated by those for whose use it is intended. Several new tables have been introduced and the older ones have been rearranged and extended. To those practitioners who have not as yet made themselves practically acquainted with the advantages and conveniences of this publication, we can cordially recommend its use.

ROYAL COLLEGE OF SURGEONS.

ON Thursday afternoon, Nov. 3rd, the annual meeting of the Royal College of Surgeons (of which a brief account was given in our last issue) was held in the theatre of the College, Mr. Savory, President, in the chair. There was a crowded attendance of Fellows and Members.

The PRESIDENT announced that the new room at the top of the College was advancing towards completion, the enlargement of the library would almost immediately be commenced, and very shortly the extension of the museum would be taken in hand. These additions would of course increase the current expenses of the College, and a large portion of the Erasmus Wilson legacy would be invested to meet them. The work of the Conjoint Examining Board in the new hall was carried out to the satisfaction of both Colleges.

The report was taken as read.

Mr. HOLMES moved: "That this meeting disapproves of the application for a new Charter, which, *first*, does not confer electoral powers upon Members of the College, and the right to be eligible to sit in the Council, in accordance with the resolution passed at the general meeting on Nov. 4th, 1886—namely: 'That, in the opinion of this meeting, it would conduce to the welfare of the Royal College of Surgeons, and would tend to promote the interests of medical polity and education (1) if Members of the College were empowered to take part (separately or conjointly with the Fellows) in the election of members of the Council; (2) if Members of the College were eligible to sit in the Council, provided (*a*) that no Member of the College shall be entitled to vote till he have been such Member for a period of ten years; (*b*) that no Member of the College shall be eligible to sit in the Council till he have been such Member for a period of twenty years; and (*c*) that not more than one-fourth of the Council shall consist of Members of the College who are not also Fellows; and, *secondly*, which does not provide that no alteration in the constitution, or in the relations of the College, or in any of its bye-laws, shall be effected without the consent of the Fellows and Members convened to discuss the same, in accordance with a resolution passed at a general meeting held on March 24th, 1884, and reaffirmed at the meeting on October 29th, 1885.'" He said the length of the resolution was due to the fact that if the meeting desired it to be laid before the Privy Council it would to a certain extent tell its own tale. There had been such frequent opportunities of discussing the matter in hand amongst each other in the presence of the Council, who were kind enough to listen to their arguments, that it was perfectly unnecessary for him to go into the merits of the question. The College consisted of 13,000 or 18,000 Members, of whom 1000 were Fellows and the rest simply Members. The calculations seemed to vary. The Calendar gave the number as about 17,000, but gentlemen who had gone into the subject said that an enormous number of them were dead and had not been struck off the list, and that the real number of Members was nearer 12,000. However that might be, it appeared to be the opinion of the Council that it was perfectly just and equitable that the 1000 Fellows should have no power in the College at all except to vote for members of the Council, and that the balance of 17,000 or 12,000 should have nothing to do with the College at all—that the College should be to them of no more value or importance than if they were not Members. He considered that that was unjust and inequitable, and that opportunities ought to be given for discussing the matter with some competent and impartial authority, in the hope that things might be set right. (Cheers.) The College had acquired enormous influence, and had lately become possessed of very considerable riches. It was not right and just that all this influence and all these riches should be used by the twenty-four members of the Council for purposes on which the Fellows and Members were not to be consulted at all, which might be according to their wishes or the direct reverse. As he said before, the Members were eager for any opportunity that could be given them of arguing the matter before any competent authority, which they hoped would set it right. They must remember, however, that in whatever way things might go in the coming struggle between the Council and its constituents before the Privy Council, if that struggle terminated in their favour it did not necessarily imply that the thing was at an end. (Hear, hear.) They had two Associations, one of Fellows which was formed originally for the purpose of obtaining some alteration in the method of the election of president and also in the method of voting. The alteration in the method of electing the president was still in abeyance, but of course that Association would attend before the Privy Council and urge its views upon that subject. Besides that, the Association of Fellows joined with the Association of Members in recommending that the Members should have the power of voting for members of the Council, and it also joined with them, although by a smaller majority, in recommending that the Members should have some admission to the Council Board. He should allow the Association of Members to speak for itself, and it would, he believed, be able to show to the authority which was to grant the Supplemental Charter that they had a very strong case indeed; but he quite allowed that before an authority such as the Privy Council the influence which they might bring to bear might possibly prevail. If so, then they must turn to Parliament, and then they might feel certain that the perfectly reasonable and moderate contentions which they put forward would prevail, and that they would before long obtain the alteration which they wish to make in the Charter of the College. Certain circumstances had taken place since the last meeting, and were recorded in the report, upon which he wished to say a few words. In the first place, the resolution which had been recited in the one which he had just submitted to the meeting was the first that was passed at the meeting on Nov. 4th, 1886; and the second was: "With a view to give effect to the recommendation in the foregoing resolution, the Council is requested to empower certain members of its body to meet and confer with the representatives of the Association of Fellows and of the Association of Members." That was met by the Council with a reply, which a little surprised the Members generally, to the effect that although the Council were not prepared to act upon the recommendation contained in the first resolution carried at the meeting of Fellows and Members, the Council were prepared to act upon the second resolution so far as to appoint a small committee to confer on the subject of the first resolution with representatives appointed by the Association of Fellows and the Association of Members. That meant that although the Council would not do anything, at the same time they would tell the Members how not to do it. (Laughter.) That appeared to be so distinct a refusal that the Members did not think it worth while to spend their time, or the much more valuable time of members of the Council, in any such proceeding, and therefore the following answer had been returned: "That considering the Council had laid down as a condition of conference that it is not prepared to give effect to the recommendation contained in the first resolution, no useful purpose is likely to be served by a conference on the subject with the representatives of the Associations of Fellows and Members, but if the Council will withdraw this condition, both Associations will be happy to appoint delegates to meet the Committee of the Council." The object of the Members was to discuss the matter to see whether the terms were in any way unreasonable; and if so, to vary them, and, in fact, to let some business be done. The object of the Council was to do nothing at all but to pay the Members the empty compliment of spending half an hour in talking to them. A still more remarkable result of the meeting of Fellows and Members last year was referred to on the tenth page. The Council then issued a circular to the Fellows, in which these two questions were asked them: "In your opinion should Members of the College be allowed to vote for Fellows as members of the Council? In your opinion should Members of the College be eligible for seats on the Council?" He thought it was a very great pity that these questions were formulated in such very general terms, because they allowed men who held the same opinions to answer in perfectly different ways. He was himself an ardent supporter of both propositions—that Members should vote for members of the Council, and that Members should sit on the Council; but he could not have answered those questions with a simple affirmative, and he was not in the least degree in favour of the Members swamping the Fellows, as they must do if they were allowed to vote promiscuously. (Cheers.) Again, he was not in the least degree in favour of members of the Council swamping Fellows of the College. He could perfectly recognise that one of the great uses of the College was educational, and hitherto that had been almost the only function which the College had performed. In all

educational questions he thought the voice of the Fellows ought unquestionably to be heard, and therefore he could not say that it was desirable to answer that second question with a naked "Yes." He thought it would have been better if the proposals that had been made had been submitted to the judgment of the Fellows, although that of course could not be considered final. The Fellows were the people interested, and it was surprising to him that the judgment of the Fellows was not far more strongly against those two propositions than it really turned out to be. The number of circulars sent out to the Fellows was 987, of which twenty-one seemed not to have arrived at their destination, so that 966 Fellows were consulted by post. In return to the first question of the Council 419 Fellows voted "No," which was very considerably below the majority required; 276 actually voted "Yes"; while 260 did not take the trouble to vote at all, and therefore could not have any powerful objection to the question asked. That made 536, which was a very great majority of the Fellows. He therefore thought he was entitled to say that the majority of the Fellows had no objection to entrust the vote to the Members under such conditions as would not swamp them in their own College. (Cheers.) At any rate, it could not be said that even in the judgment of the Fellows the proposal which was carried at the meeting was in any way negatived. However, the Council, he supposed, thought that they had the sanction of their constituency, and they accordingly went on to lay the Draft Supplementary Charter before the proper authorities, but before they did so the Association asked them to meet and discuss the Draft Charter. It could hardly be said that at the meetings held hitherto anything had been discussed, except among the Members themselves. The Members talked, and the Council acted. (Laughter.) The Council, however, replied that they "do not think it expedient to convene a general meeting of the Fellows and Members to consider or discuss the proposed Draft Charter, as the subjects to which it relates have already been submitted to meetings of the Fellows and Members." It was true that the subjects had been submitted to the meetings, but whether they had been approved or not was another matter. The first provision of the Draft Charter was a very necessary one: "To enable the College to hold 'lands, tenements, rents, and hereditaments,' of annual value not exceeding £20,000, instead of £2000, as by present Charter." It seemed funny that the £2000 a year included the premises in which that meeting was held, and the partnership with the College of Physicians put them in possession of another—whatever it was. (Laughter.) Still no person would think of taking any pettifogging objection to the position in which the Council now found itself. The third provision was to empower the Council to elect to the Fellowship Members of twenty years' standing, not exceeding ten each year, on the payment of the fees required for the Fellowship examination. That appeared to be the same proposal that was protested against most strongly by the Fellows and Members. It was on the motion of one Member, seconded by another, that the general meeting said the first method recommended by the Council for widening the basis on which the Fellowship was obtained tended to lower the academic status of the diploma, and that in the interest of surgical education it was not advisable. The proposal in the Supplementary Charter tended directly to lower the academic status of the Fellowship, and ought to be protested against by every person who had the interest of surgical education at heart. The only other provision of the Supplementary Charter of any real importance was the one giving the Fellows power to vote by voting papers. One or two other matters were so remarkable that he could not pass them over when recommending the resolution. The first was the behaviour of the College in the matter of the Society of Apothecaries and the new conjoint examination. The last meeting of the Fellows and Members respectfully urged upon the Council the advisability of an arrangement for combination with the Apothecaries' Society as well as the College of Physicians, but that strong expression of opinion was only worth the breath expended upon it. The Council went on to do just as it pleased. Then the General Medical Council requested them to reconsider their policy, but the College replied in that highty-tighty, mind-your-own-business style which was so agreeable when applied to other people. That was the masterful way in which the Council of the College managed business. That state of things ought not to be permitted to continue. Matters so important to medical education and to the status of every medical practitioner in the kingdom ought not to be settled by private bodies in that way; the opinion of the profession ought to have some weight, and ought to be elicited in some way. Similar observations might be made with regard to degrees in medicine, which was one of the most thorny subjects connected with the profession. That was a matter on which the medical public ought to be consulted. How would the granting of those degrees affect men at present in practice? The only other thing he would notice was the large accession of property which the College had lately received and was expected to use for the benefit of the profession. Nobody charged the Council with anything like corruption; but there, again, they claimed to be the absolute masters of that large fund. That large accession of wealth would not make the College in the least degree more apt in the defence of the interests of the general practitioners who formed the bulk of the Members, in the amendment of the laws, nor in the abatement of any of the other crying abuses. All those matters would have to be submitted to the judgment of some impartial authority. He was very sorry it should be so—sorry to say that the Council was not in harmony with a large proportion of its members; but there was no question that such was the case. No attention whatever had been paid to the humble, respectful representations that had been made to the Council, and the Members therefore had no choice except to see whether they could not win in what had now become a simple fight. For his own part, he had no doubt as to how that fight would terminate, however long it lasted. It was not consistent with everything else that went on in this country at present to suppose that a great institution such as the College was could be entirely given up to the uncontrolled management of two dozen gentlemen (cheers), however adequately they performed their duties, and that all the rank and file should be entirely excluded. He moved the resolution with all possible confidence that it would prove acceptable to the meeting, and he trusted that they might be able to impress the Privy Council so strongly on the subject that the Supplementary Charter would be sent back for reconsideration. (Loud cheers.)

Dr. RALPH GOODING, in seconding the resolution, said he did so with pleasure mingled with sadness: pleasure, because he was raising his voice for the promotion of the welfare and future progress of the College; and sadness, because of the utter indifference of the governing powers of the institution to the crying evils and the marked indignities which had been heaped on their constituents for more than half a century. They had not only failed to redress those evils, but were now actually seeking to perpetuate them. In the report two matters were principally dealt with. In the first place, they were asked to approve of the expenditure of some £50,000 or £60,000 in additions to the College premises. That might be right or wrong, but when they found that the cost of the new dwelling house alone was estimated at something like £10,000, and that equal accommodation could readily be procured at less than one-fifth of that amount, they might fairly infer that the subject was open to discussion. Were they to conclude that consulting surgeons living in the atmosphere of metropolitan hospitals, and carrying on their profession in a West-end square or thoroughfare occupied by the aristocracy, were more competent to deal with building operations than many other Members of the College? For his own part, he believed that the leaders of the profession would do well to look for advice in such matters to the general Members who lived in the suburbs and provincial towns. The admission of Members to the Fellowship by election meant one thing and one thing only—the sale of the diploma to the highest bidder; but they were pledged to resist to the utmost any proposal which in any way might detract from the value of that academical distinction. The College was the *alma mater* of the Members, but they had been driven from their surgical home. However, they did not despair; they had a natural longing to return, and were filled with the deepest aspirations to succeed to the privilege of their surgical birthright by undertaking their fair share of the responsibility of the government and direction of the College. He trusted that the meeting would mark its sense of the justice and rectitude of the course put before them by unanimously voting for the resolution. (Loud cheers.)

Mr. GEO. BROWN thought the Council had not exercised good judgment in opposing the reasonable demands that had been put before them. They could no more control the

movement than they could stop the advancing tide, and they would again fail as they had done in their attempt to snuff out the Apothecaries' Company. In the latter case they would neither listen to the meek voice of the Members nor to the request of the General Medical Council. The result was that they had been hoisted on their own petard, and now they had a competing body whose examination would bear favourable comparison with that of the College, and whose qualification was more than equal to their own. (Laughter.) He wished to ask the Council through the President if on this occasion they would deign to do what they had never before done—attempt to reply to some of the remarks that the Fellows and Members had made. For whom did they hold the great funds that had been bequeathed to the College—for themselves, or in trust for the members? That was a pertinent question, and one that was entitled to a reply. He maintained that they held them in trust, and therefore the Members should have a voice in the disposal of those funds.

Surgeon-Major INCE said he most cordially agreed with the action of the Council in the matter of the Society of Apothecaries ("Hear, hear!" and "Oh, oh!"). He had no desire to cry down that Society; he presumed that most of those present were licentiates of it; but they were something besides, they were professional men, and he hoped something more than tradesmen. ("Question") No one would deny that the Apothecaries' Society was essentially a trades association. (A voice: "That may be, but they are gentlemen.") Wherever they had a mercenary, a commercial spirit, it must be incompatible with the spirit of a noble profession. ("Oh!") He believed there was no canker in the profession so growing and fatal as greed for money. On public grounds it was most essential that the Apothecaries' Society and the conjoint examination should be kept apart. The great want of the poor was cheap, but good, sound medical advice. (Cries of "Time.") With regard to the resolution proposed and seconded so ably, he wished to say that just in proportion as he was satisfied with the action of the Council in connexion with the Apothecaries' Society, so he was dissatisfied with their conduct with reference to the resolution. They were acting most unwisely, not only in the interests of the College, but in reference to their own interests as well. Every member of the Council must feel that the demand of the Members must be quickly answered. He cordially supported the resolution, and regretted the lamentable action of the President and Council.

The motion was carried almost unanimously, only one hand being held up against it.

Mr. JOHN TWEEDY proposed: "That this meeting respectfully requests the Council of the College to transmit a copy of the foregoing resolution to the Lord President of the Council." He said such a resolution would formerly have been out of place, but it now became in order because the Council had sent a petition to the Privy Council asking for a supplementary or renewed Charter, which did not contain any provisions which many Members who were deeply interested in the welfare of the College felt should be included in it. He would have been very glad if the difference of opinion had been settled in that room; but when he remembered how slowly political changes took place, he neither regretted nor was disheartened at the continued opposition of the Council. The executive body had come to an opinion that a certain policy was right; the general body of the Members had come to the opinion that an opposite policy was right. Year after year they had tried to settle the differences, but could not. Now the appeal was to an independent authority, and he felt that that appeal should go in a dignified way from the meeting. It was only right and just that the meeting should respectfully ask the Council to send a copy of the resolution to the Privy Council. The general body of Members were in opposition to the Council, but not in the least hostile to it. There was a fair difference of opinion, and he was quite willing to fight it out. (Cheers.)

Dr. DANFORD THOMAS said he wished to say a word regarding what the Association of Members had been doing in the interval between the last meeting and the present one. The Council had taken the question into consideration, and had consulted the Fellows. On taking the Medical Directory, which they believed to be a correct statement of those who belonged to the College and other bodies in connexion with the profession, it was found that while the College Calendar gave them 17,000 Members, in the Directory they could only discover 12,000 who were registered. Of that 12,000, something like 7000 resided out of the United Kingdom, and they had received replies from 4665, all signing the petition to the Privy Council Those had now been sent in, and were now in the custody of the Privy Council. The Association had approached the Privy Council, and had been received courteously and assured that no petition from the Council would be considered until the prayer of the Members and Fellows had also been considered. (Cheers.) He could conceive that there had been legal difficulties as to the Council giving them any direct affirmative answer. They were acting upon their Charter; they were elected by Charter under the rights which were conferred upon the Fellows in the Charter; and, standing upon their strict legal position, they thought they could not have granted the Members any rights until they had altered their Charter. The Council could, however, have put in a clause in their own petition which would have given the Members the privileges they asked for (cheers), but they had not thought fit to do so. The Association of Members would be represented by counsel at the meeting of the Privy Council, and also by deputation, and he hoped in that way the Council would be prepared to meet them favourably before the Privy Council. He had much pleasure in seconding the resolution.

Dr. ALDERSON thought it most important that they should take steps to have their views represented in the proper quarter. Last year a resolution was carried asking the Council to allow the Apothecaries' Company to join in granting a conjoint diploma, but it was perfectly useless. It was nothing to the Council to see the great number of dispensaries that were established, but it was a great thing to those Members who had to suffer from them, and also to the public who had forced upon them a number of unqualified and ignorant men. No doubt some of these dispensers held the diplomas of the College, but they must be taught not to act in a way that was injurious to the great body of Members and was also prejudicial to the public weal.

Sir JOSEPH LISTER, who was received with loud cheers, said he feared that what he was going to say would not seem at all acceptable. With reference to whether the resolution would be likely to be acceded to by the Council, it must be distinctly understood that, so far as the individual members of the Council were concerned, they must hold themselves perfectly free to discuss that question when it came before them as a Council. (Cries of "Oh, oh.")

Mr. JOHN TWEEDY said, as mover of the resolution, he did not of course wish it to be implied that any answer was to be given at once. He understood that the Council were present more in a complimentary way, and that the President was simply there to report the wish of the meeting to the Council, and then in proper course it should be considered and decided upon. (Cheers.)

The PRESIDENT said he thought it was quite understood.

The resolution was then put, and declared to be carried unanimously.

Mr. ERNEST HART said that every duly constituted meeting had a chairman, and in this case it had also a secretary. He asked, as a point of order, whether it was not the absolute and customary duty of the president or chairman of any meeting and its secretary to transmit to any authority any ordinary document which in that capacity they were requested to transmit.

The PRESIDENT ruled that Mr. Hart was entirely in the wrong. This was a meeting called to consider the report of the Council. It was not within the province of the meeting to take action of this sort. The Council was the executive body of the College, and it was their duty, and their duty alone, to take action of this kind. The resolution itself was perfectly in order, and it would be considered by the Council.

Mr. ERNEST HART moved that the resolution already passed be placed in the hands of the Chairman of that meeting and of the Secretary, with the request that they would as such transmit it to the Privy Council.

The PRESIDENT said that he could not put the resolution, because it was not within his province or the scope of his authority to do this without bringing it before the Council.

Mr. JAS. DAY asked when the Members would know what action the Council were going to take in the matter.

The PRESIDENT said he would take care that the resolution was brought to the notice of the Council with the least possible delay. The Council had certain prescribed times for meeting. How long the subject would take in deliberation he could not say, but Members could obtain any information that was required by applying to the Secretary.

Dr. PROSSER JAMES asked, with reference to the point of order just raised, whether this was a meeting of the Royal College of Surgeons of England or not, and also whether the President of the meeting was President of the Royal College or simply of the Council?

The PRESIDENT said these questions were easily answered, but they did not touch the point at issue, which was simply this—that the Council was the executive body of the College, and it was for the Council to determine their action with regard to this request, which had been most properly put to them.

Dr. JAMES.—And a meeting of the whole body of the College has no authority?

The PRESIDENT.—Certainly not of that kind.

Dr. JAMES.—No authority after it has passed a resolution to say what shall be done with that resolution?

The PRESIDENT.—Certainly not. (Laughter.)

Dr. COLLUM called attention to the statement in the report which recommended that No. 38, Lincoln's-inn-fields, now let in chambers and producing an annual rental of £368, should be pulled down and converted at an expense of £3000 or £4000 into a residence for the conservator. He thought the better plan would be to give that gentleman an extra £100 or £150 a year to find his own residence instead of practically adding £600 a year to the expenditure of the College for that purpose. The residue could be utilised in scholarships for the profession and for the sons of poorer men. The income of the College was £35,000 a year, derived from diplomas and fees. Last year the Members paid £22,859, while the contributions of the Fellows of the College on the Council was only £84. The examiners and the Council received £9685 15s. last year for their services, and that was why it was the Members were kept out. (No, no.) There was scarcely a Member of the College of Surgeons who could not influence more or less a member of Parliament (Hear, hear), and he hoped that everyone would endeavour to do so. The Marquis of Hartington lately said: "The Government under which we now live is as near an approach to a pure democracy as exists anywhere. The House of Commons practically controls the Government, the House of Commons is elected by the people. It is in the power of the House of Commons to displace the Government, and it is in the power of the people at no distant date to displace the House of Commons." He hoped that each Member of the College would address his member of Parliament and request him to appeal to the Government on this subject (Hear, hear), and then the matter would soon be settled.

On the motion of Mr. BRINDLEY JAMES, seconded by Surgeon-Major INCE, a vote of thanks was passed to the President, and the proceedings were brought to a close.

MEDICAL HISTORY OF THE EUROPEAN TROOPS IN THE BOMBAY COMMAND DURING 1886.

IN the report by W. A. Thomson, M.B., Surgeon-General, Bombay, upon the health of the European troops in the Bombay Command during 1886, the average strength for the year is stated to have been 11,000. The admissions into hospital were in the ratio of 1488, the deaths of 12·73, the invalids sent to England of 28·09, and the constantly sick of 73·98 per 1000. Compared with the results for 1885, there has been a slight increase in the admissions, but a very marked decrease in the deaths, amounting to nearly one-half. This remarkable reduction in the mortality does not, however, appear to have been the result of any alteration in the health conditions of the troops in the Presidency, but of the transfer of Quetta, at the end of the first quarter of 1886, from the Bombay to the Bengal Command. If the force at Quetta be deducted from the returns of both years, the death-rate in 1885 will be 12·49, and in 1886 14·16 per 1000, exclusive of the deaths of invalids on their passage home, thus showing an increase of 1·67 per 1000 in the latter period. There has been a decrease of about 1 per 1000 in the invaliding, and an increase of 7 per 1000 in the constantly sick. The admissions ranged between 1102 at Kirkee and 2387 at Asirgarh, and the deaths between 3·87 at Ahmednagar and 30·30 at Ahmedabad. The most fatal disease among the troops was enteric fever, which gave rise to one-third of the deaths; the admissions by it were in the ratio of 12·2, and the deaths of 4·18 per 1000. The stations at which it was most prevalent were Karachi, Deesa, Nasirabad, Poona, and Mhow. Deesa furnished the largest number of deaths. Aden, Satara, Asirgarh, and Indore were the only stations at which no case occurred. The months in which it was most prevalent were May, July, September, and October; the greatest number of deaths occurred in September. At none of the stations could the disease be traced to any specific cause. At Poona the medical officer "thinks the most probable source of the disease was 'the effervescing and sherbet drinks produced at the shops kept by natives,' and from impure water." At Karachi, although no defects were found in the barracks and their surroundings to account for it, the Principal Medical Officer says: "Much remains to be done to perfect the sanitation of Karachi. ..... At present it is simply 'honeycombed' with cesspools." The cases of enteric fever occurred chiefly, though not exclusively, among the young soldiers and the recent arrivals in India. Bombay enjoyed nearly an exemption from cholera, only 4 cases having been admitted, of which 3 died, and there was also a death at Karachi out of hospital. Two of the fatal cases occurred at Deolali, and one at Quetta, and the other admission was at Indore. Malarial fevers were the cause of one-fourth of the total admissions, but of only one death. With the exception of Quetta, which, as before stated, was occupied for three months only by Bombay troops, they were most prevalent in the Mhow division, and next to it in Sind.

There were 7 suicidal deaths recorded, and 1 homicidal. Of the former, 6 were by gunshot and 1 by hanging, by means of a piece of "puggree," while confined in the cells at Aden for drunkenness. The homicidal death was that of a private of the 2nd Lancashire Fusiliers at Nasirabad, who was shot by a comrade while trying to disarm him.

The death-rate of the officers was 8·29, of the non-commissioned officers 22·79, and of the privates 12·54 per 1000 of strength; and the invaliding was 44·20, 42·84, and 28·69 in these grades respectively.

Early in 1887 certain lock hospitals which had been closed were reopened, "and already the influence of these institutions is observable in the diminished admissions to station hospitals for venereal diseases. Sanction has also been awarded by the Government of India to the establishment, for the first time, of lock hospitals at Hyderabad and Satara," and it is anticipated that they will have an important influence in reducing the proportion constantly sick of the troops.

"PARALYSIS OF THE ABDUCTORS OF THE VOCAL BANDS."

To the Editors of THE LANCET.

SIRS,—In reply to Dr. Felix Semon, I beg to state that I had no intention of exhibiting a table of all cases published. The standard writers (Mackenzie, Ziemssen, &c.) on diseases of the larynx have not considered it necessary to include any similar table in their account of this important disease. Having collected more than double the number given by Burow in detail, I decided that this amount was quite sufficient for my purpose. I am extremely sorry that Dr. Semon's cases did not happen to come to hand amongst those sixty. Had they done so, I should assuredly have published them inpreference to many of the others. A considerable number of the instances I met with were omitted on account of insufficient detail.

Amongst the innumerable experiments on the subject of laryngeal innervation, those of Claude Bernard, in refutation of Bischoff, have always seemed to me incontrovertible; nor can I easily consign them to oblivion. Since, however, Professor Horsley's skilful experiment has finally satisfied Dr. Semon, the matter certainly demands attentive reconsideration.

Let us set another experiment by Bernard beside this one of Prof. Horsley. In a kitten five weeks old *both* spinal accessory nerves are cut. The animal becomes voiceless, but is otherwise unaffected for two days, when both recurrents are severed. Instantly it dies from occlusion of the glottis. Does not this seem to prove incontrovertibly that the vagus has a motor power not derived from the spinal accessory? In the face of such conflicting evidence I do not think Dr. Semon's expression "certainly erroneous" at all justifiable.

I am, Sirs, yours obediently,

Finsbury-square, E.C., Nov. 8th, 1887. GORDON HOLMES.

THE LANCET.

LONDON: SATURDAY, NOVEMBER 12, 1887.

WE have repeatedly drawn attention to one of those evils incidental, shall we say, to a somewhat over-ripe civilisation, with which the public mind is becoming increasingly prone to divert itself. This is the practice of self-medication—a practice which we are assured will make but little headway among a rational and simply living population, in spite of the copious fair speech of those who foster it, while it is denounced as it should be by the common voice of the medical profession. Faith in the reason, nay in the very instincts of mankind, and in the better judgment of our professional brethren, forbids us to doubt that this disguised enemy of health will eventually stand forth as a revealed imposture. This consummation is, however, the hope of an enlightened future. Meanwhile the possibilities of present mischief cannot be ignored. That these are not hidden from the majority of practitioners we are well aware, as also of the fact that many intelligent persons outside our own calling have a general sense of their existence, though the feeling is by no means as widely diffused as it ought to be. We are particularly conscious, however, of what, at all events, appears to be a very imperfect perception of these possibilities on the part of some medical men.

A feature in the recent development of literature has been the appearance of popular journals of a quasi-medical character, and the practice on the part of some of our lay contemporaries of devoting a part of their columns to the details of medical treatment. The function of these periodicals consists in an endeavour to enlarge the sphere formerly occupied by the time-old, though we cannot say time-honoured, agency of nostrums. They assume to administer, not medicines indeed, but medical advice to the public, one and all, for one penny! There is little concern for the greatly varying condition of the great army of patients—for the pulse which throbs in one and flickers in another, for the whole heart or the maimed heart, for the sound or loaded kidney, for the bloodvessels, whether they be well-nigh invulnerable in the vigour of untried youth or decaying at the brain after a life's worry. None of these things matter: the chloral, the colchicum, or the opium goes down all the same; there is the rest or the horse exercise, the full or the light diet at choice (the patient can have which he chooses, for he must know what is wrong with him), and the proprietor and the publisher are the gainers. This is what we may call the likeness in plain clothes of the newest departures in journalistic literature. Thus displayed, perhaps it may shock some, and the fact that it has not hitherto awakened more generally a natural instinct of caution is simply due to a wide-spread misunderstanding of its true meaning. If this be true of the public generally, is it remarkable that it should be in some measure true of a limited number of medical men, and—we say it with much regret—of some whose intellectual grasp and whose high sense of professional honour might have saved them from what is seen on its exposure to be so great an error? But here, again, we are certain there has been misunderstanding. The members of our profession are sometimes accused of a want of business capacity, and the accusation is partly true. Particularly is it likely to be true of those who are by their very scientific eminence debarred somewhat from the concerns which constantly occupy the purely practical man. It may be that we are to trace in this fact the cause of the regrettable indiscretion which has appended to the literature in question the nominal sanction at least of reputable practitioners. Such men would never commit themselves to such a course with their eyes open. It is to our mind far more probable that, having regard to the fact that certain general principles and certain details of hygiene or common-sense domestic management may be freely expounded without risk of misconception, they have allowed themselves to be announced as public instructors in medicine and surgery. Their distinct intention is doubtless to stop at the limit they assign themselves, but they forget to question whether this is also the design of the lay editors who solicit their literary assistance. Yet this matter is an all-important one, and there is no guarantee that they will be able to stop in their present course. There is also another consideration to which we wish to direct attention. It is this. The ground which is to be covered by the new teaching is no neglected field. It is already supervised by careful and competent visiting practitioners, not a few of them equally skilful in diagnosis and successful in the execution of practical detail. Is it wise to substitute for the care of these acute observers, working on the spot, the comparatively mechanical action of oracular dicta delivered through the popular press? We are certain that it is not, but that here we have a proceeding related, and not very remotely, to the practices of the nostrum system, and, like them, of more than doubtful advantage to the public. Let us, in conclusion, make one other suggestion, which, if it should wound, is not, we hope, too late to exercise a curative purpose. It appears to us that certain names, towards which we feel as medical men a brotherly attachment, have gained nothing, and have given nothing towards the honour of our common profession, by being found printed with ample fulness of description on broad sheets intended for universal distribution. Here, beyond question, we have advertisement on an extensive scale, and prejudice is evidently done to others equally qualified for public recognition, but deterred by a sense of justice and professional propriety from accepting it under these conditions. We cannot but think, however, that in many cases, where names and explanatory directions have been published with the same liberal disregard of professional usage, the practitioners have not been consulted in the matter.

In the foregoing remarks we have endeavoured to intimate what we conceive to be the true line of action to be adopted by medical men in the face of tendencies which, however permissible in commercial life, are incompatible with the safe and honourable conduct of medical practice. The temptation to fall in with such tendencies is, we grant, in the present age of fierce competition and general depression, considerable. We would strongly counsel, however, that

the temptation should be resisted The reward of patience will be richer when it comes, and almost any reform in existing arrangements, with a view to affording a practical outlet for professional energies, would be preferable to a system of popular prescription which too often combines the chance treatment of disease with a form of open and precise advertisement.

IN the present day we have become so accustomed to rapidity of execution in most matters that we can well imagine that, owing to the delay in its publication, the report of the Cholera Commission sent to Spain two years ago by the Royal Society and the Association for the Advancement of Medicine by Research may be received with less interest perhaps than it merits. It is true that nearly a year ago the Commission made a preliminary report to the Royal Society, and the delay in the issue of the complete report, which appears as one of the pamphlets of the Association,[1] is explained by the desire of the members to incorporate the results of a subsequent inquiry on the subject, conducted by Dr. SHERRINGTON in Italy in 1886. As this addition makes an important correction in the general result, it is not altogether to be regretted that Drs. ROY, GRAHAM BROWN, and SHERRINGTON have taken time before submitting their conclusions to criticism. The general impression gained on reading the report is that it has been drawn up with candour and painstaking care, but that its results are disappointing, and, indeed, somewhat barren. It cannot be said to have advanced our knowledge of the pathology and etiology of cholera; but for all that it is worthy of careful attention, since it deals with the subject in a spirit of impartiality, which is too often absent in similar inquiries.

The report opens with a brief sketch of the researches upon micro-organisms and cholera, from KOCH'S discovery of the comma bacillus onwards, the support accorded that discovery by VAN ERMENGEN, NICATI, and RIETSCH, and the adverse conclusions of KLEIN and GIBBES. Whilst admitting the fact that the introduction of the comma bacilli into the intestine of guinea-pigs is to produce diarrhœa and often death, it is held that the disease so produced, which is accompanied by free development of the bacilli in the canal, is not identical with cholera; at the same time it is not septicæmia. This statement forms, as will be seen, the groundwork of the conclusion arrived at by the Commission with respect to the position of the comma bacillus in the disease. Before adverting to this it will be convenient to follow the investigations which were made by the Commission in Spain, whither it was sent to reconcile if possible the contradictory views put forward by KOCH and his followers on the one side and Drs. KLEIN and GIBBES on the other. Post-mortem examinations were made on twenty-five cases, at the shortest possible interval after death, and with all due precaution to avoid external contamination. Nothing of importance was added to our knowledge of the morbid anatomy and histology of the disease; although it is curious that whereas in Spain the intestines very rarely presented evidence of ulceration and catarrh, in Italy ulceration and sloughing were very frequently met with. The absence of signs of catarrh in most cases is adduced as evidence that this is not an essential part of the choleraic process; and further that the intestinal flux is not due to irritation of the mucous membrane, but to hyper-secretion similar to that produced in MOREAU'S experiment of section of the mesenteric nerves. Hence it is inferred that the cause of cholera, if an organised ferment, is more likely to be found in the mucosa itself or its nerves than in the intestinal contents. Naturally the greatest interest attaches to their researches upon the micro-organisms met with in this disease. Comma bacilli were found in the fluid and mucous flakes in all cases, with the exception of six or seven; and although it is possible that a more extended search would have revealed their presence in these cases, yet it is noticeable that in the majority these organisms were decidedly sparse, and certainly not in excess of other microbes. These other organisms included a small diplococcus of especially frequent occurrence, and "numberless varieties" of straight bacilli. Cultivations on the methods of KOCH also confirmed the fact of the scarcity of comma bacilli, which even KLEIN and GIBBES had found to be more constantly present than this Commission has. The same departure from KOCH'S results was obtained in their examination of the mucosa itself; for their "results confirm fully those of STRAUSS and KLEIN as to the absence of any comma bacilli in the mucosa of the lower or other parts of the small intestine in the great majority of cholera cases"; and no confirmation was obtained of KOCH'S statement of the number present in the mucous membrane bearing any definite relation to the acuteness or severity of the attack. It is plain, therefore, that, on the grounds adduced by KOCH, the Commission cannot accept his inference on the causal relation of the bacillus to cholera.

Another branch of this inquiry was with respect to the method of protective inoculation introduced by Dr. FERRAN of Valencia. Dr. FERRAN himself was not seen, but several specimens of his culture fluids, which had been sent by the Spanish Government to Aranjuez for the inoculation of soldiers, were examined for micro-organisms. They did not contain the peronospora-like bodies described by FERRAN, but were impure cultures of various forms of bacilli and micrococci. With admirable justice the reporters admit that these cultures may have been contaminated after leaving Dr. FERRAN'S hands, but it is quite evident that they are unable to rely upon the accuracy of his observations, whilst they do not hesitate to point out the risk of septicæmia to which those inoculated with these impure cultures were liable. As regards the other microbes discerned in cholera (the straight bacilli of EMMERICH and of KLEIN), the results of this inquiry are quite negative. EMMERICH'S bacillus was not discovered by following his methods, and it is concluded that it is a septicæmic form accidentally present in certain cases.

So far, then, the inquiry seemed to issue only in a failure to confirm previous observations; but the considerations above adduced upon the probable seat of the virus led the Committee to a diligent search for evidence of the presence of a micro-organism in the mucous membrane. Granules stained red by fuschin, like the nuclei cells, were observed in this tissue, but no significance was attached to them until they happened to be detected in the kidney of one case, in

[1] Kolckmann, price 6d.

the lymph space outside the membrana propria of one of the tubuli contorti. The granules there seemed to be nodal swellings in a fine filamentous network or mycelium. By adopting other methods they went back upon their specimens, and eventually demonstrated the presence of this or some allied structure in every one of the twenty-five cases. That it could not have been introduced by accidental contamination after death was evident from the depth at which it occurred, and the fact that some of the examinations were made immediately after death; and the precautions adopted were such as to preclude such contamination. The first opinion as to the nature of this parasite—viz., that it belonged to the chytridiaceæ, which Mr. GARDNER had believed—has been modified by that gentleman, who now thinks that it is an involution form of some bacillus. But its precise significance remains in doubt. In not one of the specimens obtained in 1886 in Italy could it be found, so that those who may have thought that herein lay the cause of the disease are doomed to disappointment. Hence it is that the investigation has been comparatively barren; but, singular to state, it has not materially weakened the position of the comma bacillus. For in their "conclusion" the investigators state that not only is it a distinct species, but that it is distinctly related to cholera. (There is an unfortunate omission of the word "not" in a passage relating to this on p. 19.) For although their inquiry has led them to discard the idea that it is the direct cause of the disease, they cannot regard its presence as either harmless or accidental. They suggest that it does bear a causal relation to the premonitory diarrhœa, and is therefore an indirect cause of cholera, to which such diarrhœa disposes. Yet even this qualification is further qualified by an expression of regret that their inquiries in Spain "had not advanced sufficiently far to convince us that KOCH'S comma bacillus was not the direct and only cause of cholera," and that they therefore did not study the micro-organism of the dejecta from cases of premonitory diarrhœa.

THE benefits which have been conferred upon the English people during the fifty years the QUEEN has ruled over this country have been during the present year the subject of universal attention. The Empire has prospered and grown, the necessaries of life have been rendered more available for all, and there has been a steady advance in the social improvement of the people. Perhaps the public health administration, which has had its birth in this period, has been more instrumental in fostering this social improvement than any other power which has been in force. Work such as that undertaken by the late Lord SHAFTESBURY, and which aimed at the promotion of cleanliness of mind as well as of body, had its natural outcome in the scientific study of the means of preventing disease. The admirable address which Dr. THORNE THORNE, the newly elected President of the Epidemiological Society, delivered on the 2nd inst. places forcibly before the profession, and we hope before the public, the great gain that has accrued to the population from our better knowledge of the etiology of disease and of the requirements of life.

Dr. THORNE properly claimed for our system of registration of causes of mortality that it was the beginning of preventive medicine. Until it was possible to know with some precision the proportions in which the population died from different diseases, the effects of conditions inimical to life could not be appreciated. To the admirable development of that system at Somerset House, and to the accuracy of the reports which emanate from that department, we are indebted in no small degree for the progress of which Dr. THORNE was able to give account. It made possible to be known the duration of life in country districts and in large towns, and has given opportunity for the local circumstances which gave rise to an undue mortality to be accurately studied.

England may without boasting claim that she has taken the lead not only in gaining knowledge of the conditions which are concerned in the production of particular diseases but that she has also been first in modifying her laws and in creating a public health administration in response to this teaching. Dr. THORNE took as an illustration of the benefits which had been conferred on the community by these changes the reduction in the death-rates from certain special diseases. Fifty years' experience of small-pox had provided data by which the extent of the usefulness of vaccination might be better defined. The Vaccination Acts passed in Queen VICTORIA'S reign had led to a vast saving of life, and especially of child life, and these had especially protected those who are unable to guard their own interests. "Fever" had been found to consist of at least two different diseases—typhus and enteric fever; the former largely due to the crowding of people in houses and of houses on a site where air and light were shut out; the latter mainly due to excremental pollution. Each required its special means of prevention, and these had been applied with astonishing results. London had spent fourteen millions of pounds in the improvement of unhealthy areas, and among the results might be cited the almost complete disappearance of typhus from the metropolis. Enteric fever had enormously diminished, and this had been brought about through the adoption of methods which the new knowledge showed to be necessary. Further investigation had indicated the different channels by which disease could be disseminated; BALLARD and MICHAEL TAYLOR had demonstrated the part that milk could play in the diffusion of enteric and scarlet fever; POWER and KLEIN had shown how milk-scarlatina had its origin, and had proved the urgent need for human and veterinary medicine to work together for the saving of human life; BUCHANAN had taught that phthisis, the scourge of the British Isles, was chiefly dependent upon conditions of soil which could be removed. These are but a few examples of the additions to knowledge which the work of the last fifty years has produced. Not least in importance must be reckoned the development of a system of precise investigation, which will confer in the future even greater benefits than those experienced in the past, and to the perfecting of which the new President of the Epidemiological Society has conspicuously contributed.

Dr. THORNE, at the conclusion of his address, not unnaturally touched upon the complaint of some that the country is already over-populated, and that the saving of life which was being effected was already creating difficulties which must increase as time went on. To this he had a sufficient reply. Preventive medicine aimed not only at the reduction

of death-rates, but at the diminution of disease; the result, he said, of applying its principles to public health operations had conduced to individual and national prosperity, to greater enjoyment of life, and to capacity for greater power for remunerative occupation. There is, indeed, no question that happiness is brought to the greater number by the diminution of disease and death; and it may be said of the Victorian era that in this period the work necessary to effect this object was first seriously undertaken by the State.

IT is not amiss at this early stage of the session of our various Medical Societies, metropolitan and provincial, to suggest one department of medical knowledge to which they do not make so many contributions as is desirable. The little attention that is given in our Societies to therapeutics, including the action of medicines, is remarkable, and is not a little to be regretted. For one thing, surgery has a large share of the time and attention of our Medical Societies. Dr. BURNEY YEO, at the last meeting of the Clinical Society, humorously complained that the great cavities of the body, in which the physician used to see a safe domain for the exercise of his art and the operation of his prescriptions, were being invaded one by one by the surgeon. The brain had gone over to his care, the thorax was not safe from his interference, and now even the abdomen was threatened with surgical procedures which would supersede and eclipse the more indirect and mysterious methods of the physician. There is a considerable amount of truth in this view. But the physicians are not so discredited after all. It is by their careful diagnosis and their discriminating pathology that cases are defined and the line of treatment is indicated. The surgeon in such cases is, as it were, the complement of the physician, who sees in aspiration or laparotomy a more ready way of removing the consequences of inflammation than by the old antiphlogistic and absorbent routine. But after allowing fully the brilliant part played by surgery even in the cure of internal diseases, hitherto left almost solely to physicians, it is surely true that physicians too readily abandon the Societies to the surgeons, and refrain with much modesty from discussions on the medical aspect of therapeutics. It is impossible to deny that therapeutics has undergone a very great development of late years. The action of drugs is better understood, and so is the action of foods. But if we look into the Transactions of our great Societies for any contribution on the action of medicines, we shall look almost in vain. Take, for example, the last admirable volume of the Clinical Society's Transactions: there is but one paper of a conspicuously therapeutical kind, and that is the work of a surgeon. Mr. TREVES describes a case of glandular disease in a patient over sixty. Numerous enlarged glands occupied both sides of the neck, from the jaw to the clavicle. Mr. TREVES might have taken his knife to remove them. But instead of taking his knife, like a surgeon, he took his pen, like a physician. He prescribed arsenic, and the tumours vanished. He was as confident that he had removed the disease with arsenic as if he had removed them surgically. His words were: "I think it would be safe, quite safe, to infer that the cure was entirely due to the arsenic"; and in support of his contention he adduces evidence of the curative effect of arsenic in certain malignant or quasi-malignant gland tumours from a striking paper by Dr. KOBEL of Tubingen. Of fifty-nine such cases, seventeen were cured. The action of the same drug has been the subject of a very suggestive communication to the same Society during the present session by Dr. HANDFORD of Nottingham. Dr. HANDFORD brings out strongly some effects, hitherto little regarded, to be obviated if possible, and which constitute a subject for careful and continuous consideration.

There is evidence, on all sides, of life and activity in therapeutics. Surely it should find more expression and discussion in our Medical Societies. So much is this defect felt in some quarters, that a new Society is being constituted, to devote itself solely to therapeutical questions. Would it not be much better to use the Societies at present existing, which abound in men rich in knowledge of the action of drugs? Some of us can remember that the Clinical Society, in particular, was started to be, above all things, therapeutical. Sir THOMAS WATSON emphasised the necessity for such a direction of its work in the Inaugural Address which adorns and initiates the Transactions. The Society has well justified its existence, but scarcely in this particular direction. It has not yet realised the mission prescribed for it by Sir THOMAS WATSON, "to bring up the therapeutic departmental of medicine to a nearer level with those other parts which are strictly ministerial and subservient to this." Surely every Medical Society should have a Therapeutical Committee, whose special function it should be to take note of the action and uses of medicines, and the forms in which their best effects might be attained and their deleterious action minimised. At any rate, such a function should be cultivated by a Society whose formation excited, in the mind of Sir THOMAS WATSON a belief "that it will hereafter be spoken of as the starting-point of a vast and solid improvement in that which is our special office in the world—the scientific and intelligent exercise of the divine art of healing."

Annotations.

"Ne quid nimis."

THE ANNUAL MEETING AT THE ROYAL COLLEGE OF SURGEONS.

THE annual meeting of the Fellows and Members of the College on the 3rd inst., of which we give a report elsewhere in our issue, in years to come will be memorable on account of the unanimity which characterised the proceedings, and that, too, notwithstanding the presence of many independent Fellows and Members—that is to say, of Fellows and Members not affiliated with either of the Associations. Not a single voice was raised in defence of the *status quo*, behind which the present Council so stolidly shelter themselves. Another circumstance of considerable interest was the impatience manifested by the meeting during the speeches of one or two speakers who wandered from the subject matter of the meeting. On such occasions as the annual meetings it is quite impossible to discuss details. Broad and general principles only can be adequately advanced, and these must be placed in the hands of the ablest men that can be secured for the purpose. Nothing but harm can result from individual attempts to discuss large questions such as those now at issue. Those who would discuss these questions should join one or other of the

Associations, and regularly take part in their meetings, which can be held as often as may be desirable, or until some general principle acceptable to a large majority has been established. This impatience was in marked contrast to the attention with which Mr. Holmes' incisive summing up of the questions at issue, and the conduct of the Council in ignoring all suggestions made to them from without, was listened to by the meeting. Almost by the time this comes to our readers the deputations from the Associations of Fellows and of Members will have been duly received by the Lord President of the Council, and we shall wait the result of these conferences with great interest. It is difficult to believe that the struggle can end otherwise than in a manner favourable to the Members. As Mr. Holmes said, it was neither just nor equitable that the 1000 Fellows should have no power in the College at all, except to vote for members of the Council, and that the 12,000 Members should have absolutely nothing to do with the College. The College exercised enormous influence, and was now possessed of very considerable riches. It was not just or proper that this influence and all these riches should remain under the sole control of twenty-four members of Council. Mr. Holmes' speech is worthy of very careful perusal; his arguments appear to us quite unanswerable, and we cannot doubt that they will receive every attention at the hands of the Lord President of the Council.

FEVER IN LONDON.

THE epidemic of scarlet fever in the metropolis shows a trifling decline, the number of cases admitted into the Metropolitan Asylums Board hospitals during the week ending Nov. 4th being 265, or 3 less than during the preceding week. The number of admissions also up to Wednesday last gives rise to the belief that this decrease may continue, since on Monday 46 cases were admitted, compared with 64 on the same day of the preceding week. There are, however, a greater total number of cases of fever in the hospitals than at any period of the epidemic, there being 2535 cases of scarlet fever, 127 of enteric fever, and 26 persons suffering from other febrile diseases. Two cases of small-pox were removed during last week to the hospitals from the districts of Rotherhithe and St. George's-in-the-East. This disease is, indeed, showing a tendency to spread which may well give rise to some anxiety. On Thursday of last week there were as many as ten patients suffering from small-pox under treatment in the hospital ships. During that week one death occurred from the same malady at Bristol, one at Birmingham, and nineteen at Sheffield, where there is a considerable epidemic. Small-pox is therefore showing some signs of becoming generally diffuse, and this occurring at the present period of the year makes it more probable that the extension will continue.

PHYSIOLOGICAL ACTION OF CHROMIUM.

DR. HEINRICH PANDER, of Dorpat, publishes an account of some researches he has made on the physiological action of chromium. The compound which he found to answer best was the double lactate of chromium and sodium. Chromic acid and its salts produced both acute and chronic symptoms, salts of chromic oxide causing only chronic or, at most, subacute forms of poisoning. The chromic acid compounds were found to be a hundred times more toxic than those of chromic oxide. The acute forms of poisoning show themselves by the disturbance of the respiration and of the central nervous system; chronic forms affect the skin and also the mucous membranes when air containing finely divided chromic oxide is allowed to come into contact with them. The heart's action was not directly affected by any of the preparations. The chief as well as the earliest morbid changes appeared in the kidneys under the form of parenchymatous nephritis, followed by the interstitial form; also in the gastro-intestinal tract, where inflammation, ecchymoses, and swollen follicles were found. There were also morbid appearances in the blood and the spleen. In chronic cases the spleen was shrunken and the hepatic parenchyma had a cloudy appearance. Chromium was found to be absorbed both when given hypodermically and also when administered by means of the gastro-intestinal tract, at least when soluble compounds were employed. Chromic acid preparations were absorbed with great rapidity, both by the skin and the stomach. When in very small quantities chromic acid and its salts were reduced to chromic oxide. The elimination of chromium took place mainly by the kidneys, but also to some extent by the liver and bowels. Death was caused in acute cases by arrest of respiration and disturbance of the central nervous system; in chronic cases by morbid changes in the blood, the kidneys, and the digestive tract. Dr. Pander was unable to find any indication as to the value of chromium as a therapeutic agent.

VICTORIA UNIVERSITY AND THE YORKSHIRE COLLEGE.

AT a meeting of the Court of the Victoria University on the 3rd inst., the application of the Yorkshire College, Leeds, to be admitted as a College of the University, was discussed on a report from the Council. For admission it is necessary that full provision for instruction in Arts, Science, and Medicine should be made to the satisfaction of the Court of the University, and as the curriculum of the Yorkshire College did not completely fulfil the requirements of the Council on the Arts side, Professor Adamson practically moved the rejection of the application. We are pleased, however, to say that broader and wider counsels prevailed, and, on an understanding that the curriculum in Arts would be extended, the application was accepted. The fusion of the three northern Colleges and Schools of Medicine into a Northern University is now complete, and the history and progress of the University since its foundation show clearly that nothing but good has resulted. A remarkable impetus has been given to the higher education in the north of England, and the anticipation of those who expected a downward rivalry in degrees from the "branding of its own herrings" by the new University has been completely falsified. We question if degrees are given on fairer terms or on a more honest and thorough curriculum than at the Victoria University. The combination of external examiners with the professors and teachers in the University has worked thoroughly well, and has led to no friction. The success of the Teaching University of the north of England is a good omen for those who urge the formation of institutions on the same lines for London and for the Midlands.

THE SANITARY CONDITION OF BETHNAL GREEN.

THE public inquiry into the sanitary condition of Bethnal Green, ordered by the Home Secretary, was continued this week by Mr. D. Cubitt Nichols and Mr. Shirley Murphy, the Commissioners appointed for this purpose. Evidence was given by Dr. Bate, the medical officer of health, by the surveyor, sanitary inspectors, and a member of the Sanitary Committee, as well as by Dr. Louis Parkes, who had been engaged in the inspection of the district on behalf of the Mansion House Council on the Dwellings of the People. The Commissioners have also visited many of the localities which were the subject of complaint, and are still continuing their inspections. Associated with them in these duties are two vestrymen, who have been appointed by the Vestry of Bethnal Green at the request of the Home Secretary.

THE ROYAL BERKSHIRE HOSPITAL.

THE election of a physician to the Berkshire Hospital took place on Tuesday, Nov. 1st, in the presence of an unusually large assembly of the governors of the hospital, brought together by the interest excited in the election by the publicity given to it in our own columns and in those of the local press. It is the privilege of the medical and surgical staff of the hospital to select from among the various candidates and recommend the two most eligible to the governors. This accordingly was done. The two candidates selected were Dr. Burgess and Dr. Moody Ward. On the day of the election it transpired that Dr. Burgess had retired, and that Dr. Moody Ward was the only candidate remaining. It was, however, announced at the meeting that the medical staff did not consider him eligible. One of the governors, who is known to take a great interest in the hospital, proposed that the election should be postponed. It is difficult to reconcile the action of the medical staff in recommending Dr. Moody Ward as one of the two most eligible candidates, and, when his election was rendered inevitable by the retirement of the other candidate, in pronouncing him ineligible for the appointment. Their inconsistency was at once evident to the governors present. An amendment was proposed by one of the vice-presidents and seconded by another, that the meeting should proceed to the election of Dr. Moody Ward. The Secretary was directed to read this gentleman's testimonials, and his claims to the appointment were considered unimpeachable by a large majority of the governors. He was therefore elected in opposition to the recommendation of the medical staff, but, we believe, to the satisfaction of the large body of practitioners who interested themselves in the election.

THE FORGOTTEN WORTHIES OF MEDICINE.

A VOLUME might be devoted to this theme, and one of its most interesting chapters would be descriptive of the heroic life and death of Eusebio Valli. That gifted Tuscan physician, whose anticipations of Pasteur's prophylactic treatment of rabies have already been noticed in THE LANCET, met his death at Havana in circumstances which do honour to himself and to his calling. From his Oriental experience with the plague, he had convinced himself that inoculation might be extended to yellow fever—as, indeed, it has quite lately been by Dr. Freire at Rio de Janeiro. In 1815 he was acting as ordinary physician to the Military Hospital at Dijon in France, and, with the sanction and aid of King Louis XVIII., he set sail on December 14th of that year for America to put his theory to the proof. Arrived at Philadelphia, he had an interview with the celebrated Dr. Moore, who warned him against the attempt; but Valli made the characteristic reply: "Believing in the contagious character of yellow fever, I propose to inoculate myself with the perspiration of the moribund from that disease, and also with the bile taken from their dead bodies, modifying the poison with the selfsame reagents I employed in my experiments on the plague of the East. If it is inscribed in the Book of Fate that I am to fall a victim in this great ordeal, my death will not be without honour." In 1816 the yellow fever did not visit North America, so Valli set out for Havana in quest of patients suffering from the malady. He presented himself to the public health authorities of that city, and they so far approved his design as to nominate two physicians, Dr. Antonio Machado and Dr. Romay (who afterwards wrote his *éloge*), to be his assessors. On September 20th, 1816, he was conducted to the Hospital of St. John the Divine in Havana, and there he found a patient from yellow fever *in articulo mortis*. Valli watched the aspect of the sufferer—the black sanious blood oozing from his mouth and from other parts of his body; and, having felt his pulse, he withdrew. He returned next day to the bedside of the patient, now a corpse. Then, before proceeding to inoculate himself with the vomit and the bile, he put on the nightgown of the deceased, saturated as it was with perspiration, and rubbed it well over his back, breast, and abdomen. He had not long returned to his abode when the first symptoms of the peculiar malaise supervened. On the evening of the next day, September 21st, he sent for Dr. Romay, who found him pale as death, his strength gone, the life rapidly ebbing. He could pronounce only a few broken sentences, interrupted by long-drawn sighs. He said: "My fate is irrevocable; I am dying." Everything that his medical friends could do for him was done; but, after lingering in a comatose state till the third day from his seizure, he expired (September 24th). The Sociedad Económica of Havana, in grief and admiration for their guest, caused his portrait to be hung in the public library of the city, an honour up to that time accorded to but two members of the Society, and they also had inscribed on his tomb an epitaph, still read by the stranger in the cemetery of Havana, and of which the following is a translation:—"To God, the All-good and Almighty. Here lies Doctor Eusebio Valli, victim to his love for mankind; the Economic Society of Havana solicits for his memory the prayers of the pious. Anno Domini 1816." A descendant of Valli's, the Cavaliere Giuseppe Valli, advocate, has recently been at pains to collect all the papers and documents relating to his illustrious kinsman, and to weave them into a suitable memoir—mainly by the help of Spanish and other foreign coadjutors, his compatriots, by their neglect of the good and great physician's name and memory, having long incurred the reproach now launched at them by his latest biographer *Nemo propheta in patria sua!*

DISEASE IN PILLOW-STUFFING.

TRADE, we know, has always had its tricks, and with most of those who practise them it matters little whether they are or are not as harmless as they are profitable. If goods look well from the outside, and if they sell well, questions relating to their internal quality and their real value are too often settled by reference to that convenient rule of doubtful equity—*caveat emptor*. The principle of this adage was probably never quite a fair one. In all cases requiring technical knowledge, and their name is legion, it must allow the dealer a distinct advantage over the purchaser. We must remember also that the former may himself have been deceived. It is not he who is primarily responsible for the hidden faults of quality by which the most cautious buyer may be defrauded. It is the maker, who, with his eyes open, provides for a cheap market not only cheap and inferior but essentially bad material. Let us quote an example. A correspondent, whose letter we publish in another column, writes to expose the dangerous but common practice of stuffing pillows with rags and scraps of clothing of every variety and degree of dirtiness. He suggests with much force that some of those outbreaks of fever which arise from time to time in schools and families from no apparent source, domestic or external, may be traceable to this dishonest and filthy custom. The maxim wherein cheap and nasty are interchangeable terms, is fitly illustrated by our correspondent's description, and the remedy for the evil he denounces is largely in the hands of the public. In part, also, it is within the power of the sanitary authority. The agents of that body must, and constantly do, destroy what they can of unwholesome bedroom litter in houses where fever has been prevalent. If they will exert their discreetly unsparing zeal for cleanliness wherever, among rich or poor, the tradesman's heedless trick is planting the seeds of disease, we may expect to see some change for the better at least in one false custom of our time.

PROGRESS OF THE METROPOLITAN OPEN SPACE MOVEMENT.

BELIEVING as we do that if London is to remain at all tolerable as a place to live in for four or five millions of people open spaces must be not only kept but created, we notice with great satisfaction the progress of the scheme for the extension of Hampstead Heath. The adjoining parishes of Hampstead and St. Pancras have given or promised £50,000; the Metropolitan Board of Works have voted £152,500; and £50,000 will be forthcoming from the City of London Parochial Charities Fund under special Parliamentary powers obtained last year. As the amount required for purchasing and laying out the 265 acres is £305,000, it is necessary that £52,500 shall be given by the public. Already half of this sum has been advanced. The inhabitants of Hampstead and Highgate have subscribed liberally. The Duke of Westminster and the Duke of Bedford give each £3000. The Baroness Burdett Coutts is one of eight donors of £1000. It is inconceivable that this great scheme should fail for want of £25,000 more. London must not be behind the provinces in such matters. Another space of thirty acres for the public has been saved at Kilburn. It has been presented by the Ecclesiastical Commissioners to the Corporation of the City of London to be maintained as a recreation ground for ever. So far so good. But can nothing be done by legislation to restrict the wholesale building of superfluous houses and the multiplication "of long unlovely streets" where fields at present contrive to preserve a precarious existence? Babylon, with little more than a fourth of the population of London, consisted of nine-tenths of fields, parks, orchards, and gardens. London is very much the reverse of this, and it is high time that some restriction was put on the merciless invasion by bricks and mortar.

DAIRY PRODUCE.

THE commanding importance of all questions relating to our food supply lends special interest to an able article upon Dairy Produce which appears in the current number of the *Quarterly Review*. The writer shows by the collation of statistics that the dairy farmers of the United Kingdom had, ten years ago, suffered themselves to be sadly surpassed by foreign competitors, and that even at the present time their enterprise leaves much to be desired. Within the last decade, however, it would seem that considerable leeway has been made up; yet the extent to which this important industry is neglected among us may be collected from the fact that the proportion of milch cows in the British Isles is one cow to 9·2 per head of population. The corresponding proportion is one to 2·2 per head of population in Denmark, one to 3·1 in Sweden, one to 4·3 in the United States, and one to 5·2 in France. In fact, Great Britain takes her rank among the very poorest nations in respect of dairy stock. It is not surprising to learn that an industry so much neglected is often conducted on very unscientific methods. The ill success of many dairy farmers is by the *Quarterly* reviewer attributed to their ignorance—ignorance respecting which he remarks that it is "of the worst possible form: the lack of knowing their ignorance. So," he continues, in pursuance of this theme, "they continue to make butter in dairies that are close to muckhills or pig's courts, or that contain meat and other things which contaminate milk." So much for the dairy process; but the milk before it reaches the dairy is sometimes subjected to treatment of which he gives the following vivid and horrible description: "We have seen milk set for cream in the living room of an Irish cabin, full of peat smoke (which makes butter bitter), and redolent of the odours of cows, pigs, and poultry kept in the place; and we have seen it set in the bedroom where a whole family slept; in some cases, indeed, the milk is set under the beds. It is impossible that even tolerable butter can be made under such conditions, and as the small farmers of Ireland are so hospitable that they will entertain their domestic animals in their dwellings, and will raise cream there too, even when they have separate buildings better suited for both purposes, the establishment of butter factories in that country is the most hopeful means of speedy improvement in butter-making." That such treatment should impair the market value of the products is not only easily intelligible, but also matter for sincere congratulation. The unwary consumer, who is liable in this way to share the perils of a squalid habitation, is in any case much to be pitied, and it is a matter of great moment to him that some substantial inducement should be held out to the producer to avoid such insanitary processes in his manipulation of an article of food. It is not alone in the direction of cleanliness that the dairy farmer is now exhorted to mend his ways. Much has been done of late to accelerate and improve the process of extracting the cream from the milk by means of a centrifugal separator. Upon the whole, the *Quarterly* reviewer makes it abundantly plain that there is great room for improvement in the processes of the manufacture of milk products, and we cordially join in wishing all success to institutions like the Glasnevin Agricultural Training Institution near Dublin, and the Munster Dairy School near Cork, which are doing something at least, and something considerable, as we are fain to believe, towards promoting a general advance in these directions.

THE LATE DR. BERNARD KRAUS.

IN the death of Dr. Bernard Kraus on the 28th ult., at the age of fifty-nine, an energetic worker has been removed from medical journalism. He was one of the founders, and has been throughout the editor, of our contemporary, the *Allgemeine Wiener Medizinische Zeitung*, which is now in its thirty-third year, and which has throughout been characterised by independence and enterprise. Amongst the distinctive features of this journal have been the reports which are given every week of the clinics of the leading physicians and surgeons in the General Hospital, and the very extended and accurate reports of medical associations and congresses, at which Dr. Kraus himself was a constant attendant. In them the late editor took a great interest, and one of his special claims to recollection is his elaborate report on the London Hygienic Exhibition of 1884, made at the request of the Commune of Vienna. He was also author of a work on Medicine, which attained two editions. His fatal illness was short and unexpected. Symptoms of intestinal obstruction had been complained of for about a fortnight, and colotomy had to be performed on Oct. 26th. The cause of the obstruction proved to be chronic peritonitis.

TUBERCULOSIS, HUMAN AND BOVINE.

DR. A. G. YOUNG, Secretary to the Board of Health for the State of Maine, has prepared a report which is of considerable importance, as summarising the information which is available as to bovine tuberculosis and its relation to tubercle in man. He regards the etiological unity of animal and human tuberculosis as established, and appears inclined to adopt the views of Johne, to the effect that we can no longer doubt the possibility of the transmission of tuberculosis from animals to man through the consumption of flesh and milk of animals thus diseased. This is a subject which calls for even more extended observation than it has received; but in the meantime it is at least advisable not to use, for human food, the products of animals suffering from tuberculosis.

If there is substantial danger, it would appear to attach much more to milk than to the flesh of the implicated animals; for, though it cannot be asserted that the interior of ordinary joints is, during the process of cooking, raised to a temperature always sufficient to destroy the tubercle bacillus, yet the cooking of meat does tend materially to reduce the danger. If it were possible to induce people only to consume milk after it has been boiled or otherwise cooked, the danger with regard to that article of diet would be reduced to a minimum. Tuberculosis is by no means an uncommon disease in cows, and it has hitherto been felt that the condemnation of the meat of such animals must, in the interests of cheap food supplies, be limited to those instances where the disease is extensive in amount or in an advanced stage. With regard to milk, we must largely trust to the inspection of cowhouses and dairies, which has now been inaugurated in this country, and which will, we hope, before long, eliminate from amongst those cows which supply milk for human consumption any that are obviously suffering from tuberculosis.

LARGE LEGACIES TO HOSPITALS.

IT is gratifying to see indications that munificent charity is not dead yet, and that out of the heaps of money which accrue to some men, and which seem only fit for generous distribution in favour of less fortunate classes, splendid donations arise. We congratulate St. George's on being the object of such a well-deserved legacy—£100,000—the third of the sort, making it now one of our well-to-do hospitals, though still not independent of annual subscriptions to the amount of several thousand pounds. Let us hope that the turn of the other hospitals will come soon. Our great hospital system presupposes men like Guy, and cannot be maintained with petty subscriptions. One of our contemporaries takes the occasion of this legacy to indulge in some criticism of the expenses in wages and salaries in St. George's Hospital, and asks if £7440 is not a large sum to pay in wages and salaries for "so small a hospital." The criticism will no doubt be considered by the authorities of the hospital. Meantime, it is only fair to say that St. George's is not a small hospital; but that on the Hospital Sunday list it comes next in number of beds to St. Thomas's, and that it compares favourably even with the London Hospital in the cost of mere management.

ANTIPYRIN IN SEA-SICKNESS.

OUR Paris correspondent writes:—"The Société de Biologie has devoted part of its last two sittings to the discussion of the different means recommended for the relief of sea-sickness. A note was presented by M. Hantz on the best way of administering cocaine, and received without any expression of opinion. M. Dupuy said that sea-sickness was more severely experienced by dyspeptic subjects, and particularly those who had dilatation of the stomach. In eleven cases he had given antipyrin in doses of from two to three grammes for a few days before embarking, and the patients had all informed him that they had been free from sickness. M. Dastre said he had instituted a series of experiments upon animals, imitating as closely as possible the movements of 'pitching' and 'rolling.' He had found that there was an incredible displacement of the abdominal viscera, which strike against the diaphragm and cause the gastric uneasiness. The body struggles with these displacements by means of muscular contractions, and the respiratory rhythm accommodates itself to them. Professor Brown-Séquard remarked that this theory of visceral displacement was very old, and one which he had been able to verify in his frequent passages across the Atlantic. It was evidently the view entertained by Wollaston, who recommended Arago to place a pad over his stomach when he crossed the Channel. M. Maurel had no doubt as to the influence of the stomach, but thought the cerebral shock also played a part in the determination of the symptoms, inasmuch as the sickness always occurs when the boat is going down, never when it is being lifted up. The best preventive was lying on the back. Beyond the statement that sea-sickness is associated with dilatation of the stomach, and the hope held out by M. Dupuy that in antipyrin we now possess a remedy for it, there was nothing new in the views expressed by the different speakers. I have referred, however, at some length to the subject, because my own seafaring experience has been somewhat extensive, extending over intervals during the last fifteen years, and including some kind of trial of every new drug recommended. Until a month ago the plan I always recommended was to take bromide for some days before going on board, and, if discomfort was felt notwithstanding, the dorsal decubitus was to be adopted. This, together with champagne, is generally what the Transatlantic captains advise. In a recent trip to New York I tried two other remedies. The surgeon of the ship recommended me tincture of capsicum, and I had also taken a supply of antipyrin. As far as one case goes, the result of the antipyrin was most satisfactory, and I can to this extent endorse the experience of M. Dupuy. The capsicum was also serviceable as a palliative, for several persons who had taken it continued to ask for it, but it did not arrest the sickness like antipyrin. A fellow passenger who suffered from dilatation of the stomach with *clapotement* was not sick at all."

PUBLIC HEALTH IN VICTORIA.

FROM the annual report recently issued by the Central Board of Health of Victoria, it is evident that useful work is in progress for the promotion of public health in the colony. The township of Elmore is especially referred to as needing active supervision; it is said to be in a discreditable state, and to favour the spread of such diseases as enteric fever. When this is the case as regards any town, it is quite evident that there is fault somewhere; for the conditions favouring that disease are, above all others, essentially removable. First it is the duty of the sanitary officials to point out where the mischief lies, and to indicate the remedies needed, and then the authority themselves have responsibility for acting. Action is about to be taken to secure proper control of dairies and slaughtering places, and an effort to deal with the failure which has heretofore taken place is to be made by the issue of stringent instructions for the local officials. Some of the health officers are at present miserably remunerated, and those who are responsible for this must also in large measure be held responsible for the unhealthiness and death which result from a failure to secure proper supervision of the conditions under which the people live; for it is well known in every branch of life that the amount of work which can properly be expected of a paid official is indicated by the remuneration attached to his office.

EFFECT OF FARADISATION ON URINARY NITROGEN.

DR. P. A. VALTER has experimented on three patients suffering from chronic hepatic disease by faradising the skin over the region of the liver twice a day for some days, and estimating the urea and other nitrogenous compounds excreted in the urine before and during the faradisation, the diet being alike all through the observations. The conclusion he arrived at was that faradisation has some trifling effect on the excretion of nitrogenous matter by the kidneys, this being slightly increased.

THE MIDDLESEX AND HERTS COMBINED SANITARY DISTRICTS.

THE difficulties of medical officers of health are well illustrated by the event which has followed a recent action of the Barnet Rural Sanitary Authority. This board, anticipating some alteration in their district, determined to reappoint Dr. C. E. Saunders as medical officer of health for one year instead of for three years, as determined upon in the other districts of the combination. The Local Government Board, having endeavoured to induce the Barnet authority to reconsider this decision, finally assented, but thereupon informed the other authorities that they must separately appoint Dr. Saunders, there being no provision in the order for the continuance of the combination hitherto existing after the secession of one of the authorities named therein, and because much delay would occur before the necessary steps could be taken for the constitution of a fresh combination. It is a distinct misfortune that this combination has ceased to exist, and it certainly is very much to be regretted that the nature of the order should require this step to be taken. Dr. Saunders has rendered considerable service to the combined district, and the public would be sufferers if any circumstance should tend to break his continuity of office. As a matter of fact, he has, we believe, been re-elected for each district separately, but events such as this have a disturbing influence, and are calculated to depreciate the public health service in the opinion of the profession. The duties and responsibilities of a medical officer of health are sufficiently onerous without his being subjected to vexations of this kind.

PREVENTION OF INFECTIOUS DISEASE.

A CORRESPONDENT, writing to one of our daily contemporaries, states that he has often seen clothing destined for the use of Government servants and for those in Her Majesty's naval and military services being prepared in the same room where lay a child stricken with scarlet fever, and on one occasion he found thousands of circulars being folded by the desquamating hands of a child who had suffered from that complaint. He calls attention to the work of the Westminster Sanitary Aid Association, where a few ladies have arranged to send a "visiting woman" to all cases of scarlet fever notified to them by medical men, and he speaks of the success which has attended these efforts in inducing parents to send their children to hospital. Where due discretion is used, this method is calculated to prove of great value in checking the spread of contagious disease, and might well be adopted in other districts.

ASSURANCE FRAUDS.

THE recent disclosures in connexion with various assurance frauds are rather disquieting, since they show the comparative ease with which certain needy members of the medical profession may be induced to take an active share in a dishonest proceeding. The now famous Von Scheurer fraud would have been an impossibility but for the active co-operation of a French medical man, who supplied, at the moment when he was wanted, a patient dying of consumption, who could be taken charge of and buried under the name of Von Scheurer. Of the unsavoury ramifications of the case it is needless to speak; they belong rather to courts of law than to us; but we cannot pass over in silence a case which so strongly affects professional credit for truth and honesty of purpose. Assurance companies repose great confidence in the skill and probity of medical men; they are consulted as to the value of the risk incurred in each individual case, and their reports are justly considered as being confidential and faithful records of the results of their observations. They are appealed to once more when a claim is made, and again, by simple statement of fact, they give information which ordinarily tends only to the confirmation of the validity of the claim, but now and then they may give some unconscious word of warning which helps to detect an attempted fraud. The value of the information thus given, and its importance to the companies by whom medical referees are employed, should render them doubly jealous of any act which must tend to shake the feeling of unquestioning confidence hitherto reposed in them. In every calling there are unworthy members, but their proceedings, such as those recently brought prominently before the public in these assurance frauds, while they call for condemnation from all honest men, must rouse the strongest indignation in those whose good name is likely to be affected by the dishonesty of members of their own profession.

THE NATURE OF TETANUS.

DR. SHAKESPEARE, pathologist to the Philadelphia Hospital, read a paper upon Tetanus before the Section of Pathology at the International Congress, in which he related a series of experiments consisting in inoculations of rabbits with material obtained from the medulla and spinal cord of a horse or a mule which had died of traumatic tetanus. The inoculations were based on the methods adopted by Pasteur in rabies, and included injections beneath the cerebral dura mater, as well as subcutaneous and intermuscular injections. He concluded from these researches that traumatic tetanus of the horse and mule is sometimes, if not always, an infectious disease, transmissible to other animals, and therefore possibly to man; and that the virus, elaborated and multiplied during the progress of the disease, is capable of reproducing the disease in other animals by inoculation beneath the dura mater. The virus is contained in the medulla and spinal marrow, and, like that of rabies, is capable of attenuation by exposure to dry air at a temperature of summer heat. It also resembles the rabic virus in producing more intense effects when inserted beneath the cerebral dura mater than when injected subcutaneously or between muscles. Dr. Shakespeare reserved conclusions as to the prophylactic effect of inoculations of the attenuated virus, and pointed out that his results, in connexion with those of Nicolayer, Rosenbach, and others, suggested forcibly the dependence of traumatic tetanus, both in animals and man, upon the action of a specific infectious virus, and the probability that man may acquire the disease from animals—notably the horse.

CHOLERA IN SOUTHERN EUROPE.

IT is now some time since regular returns were received as to cholera either in Sicily or in Malta. As regards Messina, there was still a daily cholera mortality up to the close of the first week of October, fifty-five deaths occurring during the week, but only five of them took place during the last two days of that period; and since then no news has been received. It may therefore be hoped that the epidemic as such is at an end, and that the authorities will utilise the coming winter in taking such action as shall be necessary to prevent any recurrence of cholera next summer. As regards Malta, no daily bulletin has now been issued for over a month; but this does not mean that the epidemic has ceased, for during several of the past four weeks the weekly record of deaths has reached, or even exceeded, a total of forty. But during the last fortnight a distinct diminution in the number of fatal attacks set in, and it is sincerely to be hoped that those who are responsible for the sanitary administration of the island will find themselves soon free to decide whether they had better devote their

energies to the development of a quarantine system which has utterly failed them during the past year, or whether they should not consent to learn, as the result of experience derived from the differing incidence of the disease on their healthy and unhealthy areas, that the surest method of prevention is not to close their doors against that which can certainly make its way through, but rather so to improve the sanitary state of the island that any imported infection will fail to find in their midst such filth conditions as are essential to its development and spread.

BIOLOGICAL WORK OF THE SCOTTISH MARINE STATION.

THE fourth part of the Journal of the Scottish Meteorological Society contains a paper by J. T. Cunningham, giving an account of the work done during the past three years in the Scottish Marine Station. A portion of this work was done in the Firth of Clyde, in the vessel appropriately named the *Ark*, and part in the *Medusa*, at Granton, Millport, and elsewhere. The results are highly satisfactory. Mr. Henderson has discovered forty-four new invertebrates not previously known to occur in the Firth of Forth, and one which had not previously been found in British waters. Mr. Henderson also, in conjunction with the Rev. Canon Norman and Mr. John Murray, issued a list of the Decapodous and Schizopodous Crustacea. Mr. Cunningham himself has paid much attention to the anatomy and histology of the Chætopoda, and also to the reproduction and development of the fishes of the Firth of Forth, especially of the hag-fish. He has likewise obtained and published much information of a practical kind concerning the herring fishery, and made experiments on the spatting of oysters. Researches in marine botany have been carried on at Granton by Mr. John Rattray. A list of the papers published is given. Altogether, the results of the three years' work have been very satisfactory indeed. Many naturalists have availed themselves of the opportunities here afforded them for original work for periods of varying duration.

THE SPREAD OF LEPROSY.

THE question raised by Archdeacon Wright in the columns of *The Times* of Monday last is one of considerable importance, and quite worthy of the attention which our contemporary bestowed upon it. At the same time it may be hoped that it will not lead to any attempts at legislation by panic. To the question, Is leprosy increasing in this country? no doubt an affirmative reply would be the correct one. But that such an increase depended on contagion could not be answered in so positive a manner. For it is now fairly well established that as regards contagiousness leprosy stands in the category of such diseases as syphilis and tuberculosis, which are transmissible for the most part only by inoculation. The apparent increase of leprosy in modern Europe is not due to contagion, but to the vastly improved facilities of human intercourse with foreign countries. For, apart from a few cases of the inherited disease, leprosy, in this country at least, is only met with amongst those who have contracted it in centres where it is indigenous. The recent reply of the College of Physicians to the Colonial Office indicated to what extent the State might legitimately interfere in infected districts; and the suggestion of the College that leper asylums might well be founded and maintained by the State meets the case of our colonies. The further suggestion made in *The Times* as to registration is one which cannot be carried out until notification of infectious disease is made compulsory, however desirable it may be in theory. We would, however, emphasise the importance of further investigation into the nature of the disease as a duty devolving upon the Government of an empire which contains so many subjects who are afflicted with it; and in this, unfortunately, England does not appear to advantage in comparison with Norway. Perhaps now that public attention has been called to the matter, the Government will once more seek the aid of the College of Physicians to carry out such an investigation.

HEALTH OF THE CROWN PRINCE.

WE learn by telegram from San Remo that H.I.H. the Crown Prince was progressing satisfactorily until a few days ago, when a new growth was observed lower down in the throat. This growth, we are informed, looks malignant, but of course it may only be inflammatory. A portion of it will probably be removed and sent to Professor Virchow for examination. A later telegram announces that, owing to slight œdema of the orifice of the larynx, no laryngoscopic operation can be undertaken at present.

ORGANISED INQUIRY CONCERNING ILLICIT PRACTICE IN BELGIUM.

THE Belgian Medical Federation decided at its recent annual meeting to endeavour to obtain as much information as possible concerning infractions of the laws protecting medical men by illegal practice, whether by pharmacists or by other unqualified persons. The inquiry, which it is proposed to extend over a couple of years, is to be entrusted to the various local medical associations. These will doubtless accumulate an immense mass of documentary matter, which will be submitted to a central committee for examination and analysis. When this committee has achieved its task, it is hoped that so strong a case may be made out for more stringent legislation that the Chambers will accede to the almost universal demand amongst medical practitioners for more adequate legislative protection. It was pointed out during the discussion at the meeting of the Federation that great care would have to be exercised in dealing with the information obtained so as to avoid publishing the names of informants. The Antwerp Medical Society has, it seems, got itself into considerable trouble through taking up a case of illicit practice, of which information had been given by a person who thought it his duty to bring the circumstances before the Society, but who by no means relished seeing his name brought into a controversy which was subsequently carried on in the political newspapers on the subject, comments being, of course, made which were anything but complimentary to him. Medical men will, of course, refuse information to the associations unless they have a guarantee that this kind of thing is out of the question and that their communications will be treated as confidential. An amusing instance of evasion of the medical laws was cited by M. Kops, where a gentleman who took to doctoring people asked for no money payment, but requested a licence to shoot over his patient's estate!

GERMAN ENTRANCE EXAMINATION FOR MEDICAL STUDENTS.

AN important alteration is proposed in Berlin regarding the qualification for admission to the University of medical students. Hitherto all have had to pass the *abiturienten* or maturity examination at a *Gymnasium* or classical school, so that every German medical student has been obliged to prove an acquaintance with Greek. Now, however, the authorities have decided to admit after Easter, 1888, students who have passed the final or *abiturienten* examination in the *Real-Gymnasia* or non-classical schools. In these, Latin is of course taught, but not Greek. They correspond, in fact, to the "modern" or "civil and military" departments of our own public schools.

TREATMENT OF GLAUCOMA IN SPAIN.

DR. OSIO, the eminent Madrid ophthalmic surgeon, communicates to the leading Spanish medical journal an article on glaucoma, in which he urges his medical brethren most forcibly to pay sufficient attention to eye diseases so as to diagnose this formidable malady, which is, he says, "mathematically curable" by operation if taken in time. He draws a graphic but mournful picture of a patient, in whom this affection has commenced, applying to a practitioner, who orders leeches, and then, when the severe pains come on, gives hypodermic injections of morphia and prescribes the inevitable bromide of potassium, and, above all, unconscious of or indifferent to the universally admitted fact that atropine favours the development of glaucoma, instils drops of liquor atropiæ. Besides all this, perhaps he tries insufflations of calomel and drops of nitrate of silver or borate of soda. It is a wonder, Dr. Osio thinks, that eyes treated thus do not burst.

THE ANATOMICAL SOCIETY.

AT the next meeting, to be held on Tuesday, Nov. 22nd, at University College, at 5 P.M., the following papers are to be read:—Sir William Turner, (1) "Variations in the Hippocampus Major and Eminentia Collateralis," by Robert Howden, and (2) "A Metallic Body in the Spinal Canal," by David Hepburn. (3) "Minute Anatomy of Clarke's Column in the Spinal Cord of Man, the Monkey, and the Dog," by Dr. Mott. (4) "The Arteries at the Base of the Brain," by Professor Bertram C. A. Windle. (5) "Note on the Functions of the Sinuses of Valsalva and Auricular Appendices, with some remarks on the Mechanism of the Heart and Pulse," by Mayo Collier. Various specimens and methods will also be shown and demonstrated. This youthful Society gives promise of a useful and vigorous career.

TUBERCULAR ULCERATION OF THE TONGUE.

DR. L. V. ORLOFF, of the Princess Helena Pavlovna Clinical Institute, gives an account in a St. Petersburg medical journal of a case of tubercular ulceration of the tongue, the nature of which, though there were slight signs of pulmonary phthisis, was definitely decided by microscopical and bacteriological examination. The importance of this latter means of diagnosis is pointed out by Dr. Orloff. Tubercular ulceration of the tongue, when primary, as it sometimes is, might in this way, if diagnosed and treated, perhaps be prevented from being followed up by the pulmonary affection. Some experiments were made in order to test the possibility of direct communicability by inoculation of rabbits' tongues with the secretion from the ulcer, but only negative results were obtained.

FOREIGN UNIVERSITY INTELLIGENCE.

Bologna.—Dr. Pietro Albertoni, Professor of Materia Medica in Parma, has been appointed to the Professorship of Physiology.

Göttingen.—Professor H. Schwartz, Director of the Obstetric Clinic, has announced his intention of retiring at the end of the winter session.

Messina.—Dr. Francisco Coppola has been appointed Professor Extraordinary of Materia Medica.

Naples.—Dr. Luciano Armani, Extraordinary Professor of Pathological Histology, has been promoted to the rank of Professor.

Prague (German University).—Dr. Siegmund Mayer has been raised to the rank of Professor of Histology.

Santiago (Chili).—Dr. Landwehr, Assistant in the Physiological Institute (Department of Medical Chemistry), Würzburg, has been appointed to the Professorship of Physiology.

SPEAKING at Portsmouth, on the 3rd inst., on the abolition of the Contagious Diseases Acts, Sir George Willes, Commander-in-Chief at that port, stated that a disgraceful condition of things had been the result of the abolition. It was, he remarked, no use to hope to get the Acts passed again; but matters would get worse and worse, so that it was frightful to contemplate what the condition of things would be ten years hence.

THE *Gazette* of Tuesday announces that the Queen has been pleased by warrant under Her Majesty's Royal sign manual, to reappoint Sir Thomas Jamieson Boyd, Knight, to be Chairman of the Fishery Board for Scotland; and James Cossar Ewart, M.D., Regius Professor of Natural History in the University of Edinburgh, to be a member of the said Board.

DEPUTATIONS from the Association of Fellows and the Association of Members of the Royal College of Surgeons will to-day (Friday) be received by the Lord President of the Council, and will lay before him their reasons for opposing the Supplemental Charter sought by the Council of the College.

WE beg to direct the attention of our readers to the exhibitions at Epsom College to be competed for next month. The successful candidates, who must be the sons of medical men, receive board and a first-class education for thirty guineas a year. Any detailed information will be given by the Rev. the Master, The College, Epsom.

THERE is no diminution in the epidemic of measles at Derby, and the sanitary authority have issued circulars to the medical men practising in the town to report cases coming under their notice, in compliance with the local Act for the Compulsory Notification of Infectious Diseases.

THE Corporation of London on Tuesday decided upon giving such Parliamentary notices as will enable the Fire Inquest Bill to be extended to the whole of the metropolis if necessary.

BY the initiative of some of the senior students, a society has been instituted at the University of Aberdeen under the title of the Students' Medical Association.

AMONG the recent promotions to the rank of Chevalier of the Order of Leopold is that of the able editor of our Belgian contemporary, *Le Scalpel*, Dr. A. Festiaerts.

THE Morton Lecture is to be delivered by Sir James Paget, Bart., F.R.S., at the Royal College of Surgeons, at 3 P.M. to-day (Friday).

MR. JAMES TERVAN, F.R.C.S., who ten years ago was a well-known West-end surgeon, died last week at Bath.

QUEEN'S COLLEGE, BELFAST.—The following are the Scholarships in Medicine for 1887-88:—Anatomy and Physiology: J. M. Hall. Therapeutics and Pathology: R. W. Haslett, B.A.; Robert Wilson, a prize. Third Year Medicine: James M'Connell, B.A. Second Year Medicine: H. T. Heron, B.A.; J. A. Browne, B.A.; J. S. Morrow, B.A., a prize. First Year Medicine: Robert Montgomery, literary; T. B. Pedlow, B.A., science. Dunville Studentship: J. M. Hall; H. L. Atkinson, B.A., a prize. Andrews Studentship: Alexander Jamison, B.A.; C. E. Shaw, M.A., M.D., a prize; J. S. B. Larmour, B.A., a prize. Porter Scholarship: W. W. Haslett; J. A. Stewart, a prize. Sullivan Scholarship: James Robinson. Sir Hercules Pakenham Scholarship: J. C. Rowan.

SCOTCH INTRODUCTORY LECTURES.

UNIVERSITY OF GLASGOW.

THE winter session of the medical department of the University of Glasgow was opened on the 25th ult. The introductory address was delivered by Professor P. A. SIMPSON, who, after a brief glance at the changes that have occurred in the University since 1874, when he last addressed some words of welcome and encouragement to the students at the commencement of a winter session, proceeded to discuss at length the subject of the various channels which are open to medical graduates when they leave their university. With regard to emoluments, their profession was not, he said, one in which the realisation of a fortune was to be looked for. A fair competency was all that could be expected. The prize to be won in the medical calling did not consist of bank-notes, but in the inward satisfaction of having to some extent contributed to the extension of medical knowledge, as well as to the alleviation of human suffering. The navy offered for a young medical practitioner a career which befitted an educated gentleman. Prof. Simpson then strongly deprecated the abolition of "relative rank" in the Army Medical Staff, and advised his hearers not at present to join that branch of the services. Dealing with the question of the proportion of medical men to the population, he dwelt upon the large increase that had taken place in the number of practitioners in this country in recent years, and suggested the colonies as offering to the young medical graduate in quest of a suitable locality for his future home a sphere of usefulness much larger than was at the present time to be found at home. He was very far from being in favour of a medical career for women, holding as he did that by frame, temperament, and mental constitution woman was not well adapted for medical, far less for surgical practice; but he did not think that the members of their profession should do more than exercise a private influence against the destination of young women to the medical profession. Medical practitioners had ample opportunities of supplying information concerning the nature of a medical student's career, the difficulties and dangers of the profession, and so of tempering this unfortunate enthusiasm. But it was never, he thought, the office of their profession to lead the van of any crusade against the admission of women into their ranks. Such opposition was sure to be decried as akin to trades unionism, and it was difficult to refute the charge, however untrue. They might honestly say that the opposition of their profession to the admission of women was disinterested, and was solely to prevent injudicious women from embarking on a course which must prove injurious to them. As to the wisdom or folly of women adopting medicine as a profession, let women themselves be the judges. So long as they contented themselves with schools of their own, and desisted from clamouring for that abomination—viz., mixed classes,—they had no ground for complaint, but should rather wish them god-speed.

ANDERSON'S COLLEGE.

DR. EBEN. DUNCAN, in his address, referred to the subject of the affiliation of the medical schools of the city, and said he saw no difficulty in devising a scheme which would safeguard the interests of the present professors of the University. Anderson's College would soon have new premises, and what could be more to the advantage of medical teaching, and tend more to the advancement of University interest, than the inclusion of Anderson's College as a college of the University and the recognition of its teachers as the professors? When they had the Royal Infirmary Medical School, a younger school with the great advantage of proximity to a great hospital, also quite willing to lend a helping hand, why should the University, admittedly short-handed in teaching powers and in class-rooms, refuse the assistance which the governors of that school were now offering? He had heard only one reason against it, and that reason was that the present University professors, with their endowments, their splended buildings, and the prestige of their positions, were afraid to be exposed to the chances of teaching with younger men, who would have nothing to attract but the energy and the ability with which they conducted their classes. For that reason, it was said, the professors would strenuously oppose any reform. But, in answer to any such opposition, might it not be justly argued that if, in spite of all the advantages which the senior professors in the College at Gilmore-hill would continue to possess, even after the affiliation of both Anderson's College and the Royal Infirmary School of Medicine, they could not retain their students, then it was certainly highly in the interest of the students and in that of the public that they should lose them. The only interest which the public or the Government could legitimately have was that the student and the University should get the benefit of the best brains of the best teachers. If they could induce the Government to combine the medical schools of Glasgow into an individual teaching faculty of medicine, with their advantages they should be able to place Glasgow in the foremost place, and not only maintain but increase the reputation of their country as a great seminary of medical science.

GLASGOW ROYAL INFIRMARY SCHOOL OF MEDICINE.

DR. NEWMAN, who delivered the introductory address at this institution, took as his subject the correlation of medical studies, especially in their relation to scientific study. The mutual relationship, he said, which existed between the different branches of medical education were very apt to be lost sight of, partly on account of the arrangement of the curriculum of the students. Their general education and part of their scientific education were separated from their medical studies by the artificial barrier of an examination. So also were their elementary studies, as distinguished from the more advanced. It was common, he said, in addresses such as that which he was offering to speak of medical science, but he wished to state that medicine was not a science. If placed among the sciences it would be among the very lowest, whereas among the arts it occupied a high position indeed. If they studied, and imagined that by doing so they were scientific men, they were greatly mistaken. Medicine was far too incomplete. There were no great laws which could apply to it. It occupied, to his mind, very much the same position that the chemistry of the alchemists did. It was destined, no doubt, at some time to occupy a place amongst the sciences, but at present it was in an undeveloped and embryonic state. But medicine rested upon a number of very important sciences, and it was apt, because these sciences assisted it, to be called itself a science. The great advantage that a student had from a scientific training was that, before he entered the medical profession, not only was he taught the effects of science, but he also learned the scientific method. In his study of medicine the student was to apply this method, and by so doing to endeavour to elevate his art into the position of a science. In closing, he asked the students to remember that whatever was a real advantage to themselves was a direct advantage to some of their fellow-men. On this point the medical profession might be said to differ from all other professions. The amount of true success depended on the motives with which they entered. To those who adopted medicine as a trade—and it was the lowest of trades, for it trafficked on the ills of their fellow-men—it was neither satisfactory nor remunerative, although it might elevate them from a position of obscurity, and afford an opportunity of being associated with gentlemen. To those who entered it to study an interesting branch of human knowledge it opened a wide field for scientific inquiry. To those who pursued it with a desire to advance the healing art by exact and scientific methods, inspired with a desire to alleviate the sufferings of their fellow-men, it was a noble profession, and deserved well of all, since it was intended for the indiscriminate benefit of all.

PARKES MUSEUM.—The Right Hon. the Earl of Meath has consented to give the opening lecture of the forthcoming winter session at the Parkes Museum, Margaret-street, Regent-street, W., on Nov. 17th, at 5 P.M. His lordship has chosen for his subject "The Importance of Open Spaces." The winter programme of lectures is unusually full, and bids fair to be most attractive. Amongst the lectures we notice one by the chairman on "Smoke and Fog"; by Dr. Frank Payne on "Plagues, Ancient and Modern"; by Prof. E. M. Crookshank on "The Germ Theory"; and one by Mr. A. S. Murray on "The Physical Training of the Greeks and Romans."

VITAL STATISTICS.

HEALTH OF ENGLISH TOWNS.

IN twenty-eight of the largest English towns 5713 births and 3800 deaths were registered during the week ending November 5th. The annual rate of mortality in these towns, which had steadily increased in the preceding six weeks from 16·2 to 21·5, was last week 21·4. During the first five weeks of the current quarter the death-rate in these towns averaged 19·6 per 1000, and was 0·9 below the mean rate in the corresponding periods of the ten years 1877-86. The lowest rates in these towns last week were 12·7 in Hull, 13·2 in Brighton, 14·9 in Leicester, and 16·2 in Huddersfield. The rates in the other towns ranged upwards to 27·6 in Oldham, 29·1 in Preston, 30·7 in Bolton, and 31·0 in Halifax. The deaths referred to the principal zymotic diseases in the twenty-eight towns, which had been 392 and 464 in the preceding two weeks, further rose last week to 466; they included 144 from scarlet fever, 77 from diarrhœa, 75 from measles, 60 from whooping-cough, 57 from "fever" (principally enteric), 32 from diphtheria, and 21 from small-pox. These zymotic diseases caused the lowest death-rates last week in Leicester, Hull, and Huddersfield; and the highest rates in Bolton, Preston, Oldham, and Sheffield. The greatest mortality from scarlet fever occurred in Norwich, Blackburn, Oldham, Birkenhead, Salford, and Preston; from measles in Birmingham, Blackburn, Bradford, Bolton, and Derby; and from "fever" in Derby and Sunderland. The 32 deaths from diphtheria in the twenty-eight towns included 19 in London and 3 in Manchester. Small-pox caused 21 deaths in Sheffield, but not one in London or any of the twenty-six other large provincial towns; the 13 cases of small-pox under treatment on Saturday last in the metropolitan hospitals receiving cases of this disease showed a further slight increase upon recent weekly numbers. The number of cases of scarlet fever in the Metropolitan Asylums Board hospitals and in the London Fever Hospital had increased to 2692 at the end of the week. The deaths referred to diseases of the respiratory organs in London, which had increased in the preceding four weeks from 206 to 485, further rose last week to 506, and exceeded the corrected average by 145. The causes of 74, or 2·0 per cent., of the 3800 deaths in the twenty-eight towns last week were not certified, either by a registered medical practitioner or by a coroner. All the causes of death were duly certified in Leeds, Bristol, Sunderland, Preston, and in three other smaller towns. The largest proportions of uncertified deaths were recorded in Oldham, Leicester, Huddersfield, and Halifax.

HEALTH OF SCOTCH TOWNS.

The annual rate of mortality in the eight Scotch towns, which had been 19·1 and 22·2 per 1000 in the preceding two weeks, declined again to 20·6 in the week ending Nov. 5th; this rate was 0·8 below the mean rate during the same week in the twenty-eight large English towns. The rates in the Scotch towns last week ranged from 15·1 and 16·1 in Leith and Edinburgh, to 24·0 in Dundee, 25·9 in Perth, and 29·1 in Paisley. The 515 deaths in the eight towns last week showed a decline of 39 from the number returned in the preceding week, and included 26 which were referred to whooping-cough, 14 to scarlet fever, 8 to diarrhœa, 6 to "fever" (typhus, enteric, or simple), 6 to diphtheria, 6 to measles, and not one to small-pox; in all, 66 deaths resulted from these principal zymotic diseases, against 68 and 70 in the preceding two weeks. These 66 deaths were equal to an annual rate of 2·6 per 1000, which corresponded with the mean rate last week from the same diseases in the twenty-eight English towns. The fatal cases of whooping-cough, which had been 30, 16, and 26 in the preceding three weeks, were again 26 last week, of which 10 occurred in Glasgow, 4 in Greenock, 3 in Edinburgh, and 3 in Dundee. The deaths from scarlet fever further declined last week to 14, from 23, 22, and 19 in the preceding three weeks; 9 occurred in Glasgow, 4 in Dundee, and 2 in Edinburgh. The 8 deaths attributed to diarrhœa showed a further decline from recent weekly numbers, and included 5 in Glasgow and 2 in Edinburgh. The 6 deaths referred to "fever" corresponded with the number in the previous week; 3 were returned in Paisley and 2 in Edinburgh. Four of the 6 deaths from diphtheria were returned in Glasgow; and of the 6 fatal cases of measles, 2 occurred in Glasgow, 2 in Dundee, and 2 in Perth. The deaths attributed to acute diseases of the respiratory organs in the eight towns, which had increased in the preceding four weeks from 87 to 124, further rose last week to 131, and exceeded by 13 the number returned in the corresponding week of last year. The causes of 57, or more than 11 per cent., of the deaths registered in the eight towns during the week were not certified.

HEALTH OF DUBLIN.

The rate of mortality in Dublin, which had been 24·1 and 32·1 per 1000 in the preceding two weeks, was 31·0 in the week ending November 5th. During the first five weeks of the current quarter the death-rate in the city averaged 27·7 per 1000, the mean rate during the same period being but 19·0 in London and 18·5 in Edinburgh. The 210 deaths in Dublin last week showed a decline of 7 from the number in the previous week; they included 19 which were referred to scarlet fever, 8 to "fever" (typhus, enteric, or simple), 6 to measles, 5 to diarrhœa, 2 to whooping-cough, 1 to diphtheria, and not one to small-pox. Thus, the deaths resulting from these principal zymotic diseases, which had been 29 and 42 in the preceding two weeks, were 41 last week; they were equal to an annual rate of 6·1 per 1000, the rate from the same diseases being but 2·6 in London and 1·6 in Edinburgh. The fatal cases of scarlet fever, which had been 8 and 11 in the previous two weeks, further rose last week to 19; and the deaths referred to "fever" also showed an increase upon recent weekly numbers. The deaths from diarrhœa, measles, and whooping-cough showed, however, a decline. The deaths both of infants and of elderly persons exceeded the numbers returned in the previous week. Four inquest cases and 3 deaths from violence were registered; and 59, or considerably more than one-fourth, of the deaths occurred in public institutions. The causes of 32, or more than 15 per cent., of the deaths registered during the week were not certified.

Correspondence.

"Audi alteram partem."

"THE PRESYSTOLIC MURMUR, FALSELY SO CALLED."

To the Editors of THE LANCET.

SIRS,—I wish it were possible for me to notice in detail all the valuable communications which my humble paper has called forth, but I must confine myself to some, hoping so to select as to bring into consideration all the more important points.

Dr. Gairdner refers to a feature of the "auricular-systolic" murmur as having been overlooked by myself and others. The murmur, in his view, "may appear to be prolonged out of, or even quite through, the period of rest, being in this last case necessarily associated with a degree of the ventricular-diastolic murmur presently to be described. Its essential character, however, is preserved in every case, as above defined, and as represented in the diagram." In this diagram (in "Clinical Medicine") the sounds are indicated by vertical lines, the murmur by shading which reaches from the second to the first without a break, though not evenly, for it is lower in the middle than at either end, mounting steeply towards the first sound. Thus we have a murmur which begins while the ventricle is in the undoubted act of opening, which can be made only by a current which sets inward, because there is none in the other direction, and yet this is continuous with the murmur the auricular source of which is disputed. Dr. Gairdner does not see how this observation can be reconciled with the view I have presented. Neither do I. If the so-called presystolic murmur is continuous without break, pause, or change of tone, is all of a piece, with that which begins immediately after the second sound, then the two are one, both are auricular-systolic, and my contention falls to the ground. But I have never recognised such a murmur. I have heard not infrequently a soft apex murmur in the diastole close upon the second sound, the old mitral diastolic, and I have known this to be followed by the characteristic note of the so-called presystolic, but never without a break. Dr. Gairdner suggests to me, as the only course open, to explain the

supposed single murmur as two; this suggestion I adopt, not with any intention of warping facts to suit a controversial purpose, but as representing the evidence of my own ears. I may be wrong, and am the more likely to be so since I am opposed to an auscultator of Dr. Gairdner's proved skill and experience; but my conviction is as I have stated it. I have heard, not often, for such cases are rare, but as I have thought clearly, the old mitral diastolic followed after an interval by the so-called presystolic; but the murmurs to my ear have always been separate in time and different in character. Dr. Gairdner, indeed, "is not indisposed to admit with Dr. Balfour that the diastolic element of this murmur is softer, as a rule, than the presystolic; and that it may also occur in some cases where the latter is indistinct or perhaps even absent."[1] Dr. Gairdner admits the existence of these cases "with some difficulty," for to admit them is to admit the old mitral diastolic murmur and mark a distinction between it and the so-called presystolic. The difference between Dr. Gairdner and myself on this point is but of small, and I hope lessening, dimensions; it is nothing more than the halt of a stammerer, or a hyphen between two syllables; but it implies much.

To take another particular which relates to the continuity of murmurs. In presenting the general conception of the "presystolic" tune, and while disputing its meaning describing the sounds involved according to common acceptance, and as I thought correctly, I spoke of the so-called presystolic murmur as "running up to the systole, as being united to the systolic sound without separation, and as being *inseparably blended with the systolic murmur, should there be one.*" I was here referring, not especially to Dr. Gairdner, but to the presystolic creed as generally held. How common a clinical experience is it for a murmur which has been under discussion as to whether presystolic or systolic to be satisfactorily settled as a presystolic running into a systolic. How often it happens (and here I speak for myself) that a so-called presystolic and an undoubted systolic are associated, variously interchanging, sometimes more of the one, sometimes more of the other, but never separated by any definite demarcation. I need scarcely recur to my purpose in insisting on this fusion in repute and in fact. The argument is simple. I say it is impossible for an auricular systolic to mix with a ventricular systolic, for the blood is going different ways. The so-called presystolic thus mixes, therefore it is not auricular. Dr. Gairdner here protests against admitting this mixture of murmurs. But in the oft-quoted "Clinical Medicine" (p. 557), in speaking of the various combinations of murmurs, he says: "It is not unusual to have an auricular systolic and a ventricular systolic murmur combined as in the figure; *they may even appear to be so combined as to constitute but one murmur;* you will commonly, however, be able to detect the first sound in the middle of this murmur, splitting it, as it were, into two." (The italics are mine.) The diagram represents the supposed two murmurs by continuous shading, through the densest part of which a line passes to indicate the position of the first sound, but no interval is represented. Again, Dr. Gairdner says, in speaking of combinations of murmurs, "The greatest degree of difficulty" in distinguishing them "is when the normal sound is merged in the murmur, as it often is when an auricular-systolic and a ventricular-systolic are combined," and then Dr. Gairdner goes on to explain that the distinction rests on a difference of tone between the former and latter part of the combination, the former represented by repeated *r's*, the latter by repeated *f's*. Dr. Balfour also gives a figure[2] similarly constructed to Dr. Gairdner's, which is designed to show "a diastolic murmur separated from the succeeding presystolic murmur by a pause, while *the auricular-systolic murmur passes directly into a ventricular-systolic one.*" (The italics are mine.) The diagram shows a space between the shadows which represent the diastolic and the presystolic murmurs, while the presystolic shadow is continued into the following systolic, though a line through its densest part marks the position of the first sound. I quote these descriptions of Dr. Gairdner and Dr. Balfour in the belief that they are absolutely correct as representing what is heard, apart from any differences of opinion as to what the murmurs should be called, and how explained. What I doubt is not whether the murmurs so mix, but whether the two which so mix are made in opposite directions. But now Dr. Gairdner insists with more emphasis on the separation of these murmurs than on their union. This involves, as will be seen, an important admission. "I have been at the utmost pains to show," says Dr. Gairdner, "that these two murmurs are never thus inseparably blended, that they always preserve their exact separate rhythm, and are sharply demarcated from one another, either by the first sound remaining clear and definite (as it usually does) between the two, or by an abrupt change in the character of the murmur itself, marking, as it were, an interval between them (though the interval may be too brief to appear *soundless* to the listening ear)." Even now we have not got to an interval, but only to an interval "as it were." But at least there must be a sharp demarcation of some sort, in the absence of which I gather that Dr. Gairdner would not allow the murmurs to be of opposite kinds. I can only rejoice that so great an authority should concur with me on so important a point as the necessary separation of an auricular-systolic from a ventricular-systolic murmur. I shall henceforth hold with increased tenacity to the belief that a murmur which runs into, or coalesces with, an undoubted systolic is not presystolic, but only falsely so called. We have here a test which will, I think, be decisive against many murmurs which have hitherto passed as auricular.

I will take Dr. Balfour's letter next, for part of it is answered by what I have already said in reply to Dr. Gairdner. To take Dr. Balfour's points in their order: He thinks it "remarkable that the ventricle should be supposed capable of producing this loud rough murmur at the first beginning of its systole, when it is acknowledged that as this systole nears its acme and gains in force the murmur grows less and actually becomes soft and blowing." I thought the murmur, as a rule, began feebly and gathered strength as it went on—a mode of proceeding which might be expected, presuming it to be of ventricular origin. Again, in referring to the time of the mitral diastolic murmur, I had spoken of a period after the conclusion of the systole during which the ventricle "waits empty and still." This is not important for the purpose of the argument, but Dr. Balfour spies an error and quotes Hope to the effect that "the expansion of the ventricle immediately succeeds its active contraction," and, adds Dr. Balfour, "I know of no modern observations tending in the least degree to invalidate this statement." Let me refer Dr. Balfour to the well-known text-book of physiology by Dr. Michael Foster, fourth edition, pages 149 and 154, where he will find evidence that "the ventricle continues contracted after its contents have entirely left the cavity," and that the time for which it does so has been the subject of measurement. And now Dr. Balfour, by way of giving me the *coup de grace*, being already sore wounded, takes up anew a point which has already been dealt with by Dr. Gairdner. Says Dr. Balfour: "Dr. Dickinson objects to the term *continuous* being applied to the double murmur audible at the apex in many cases of mitral stenosis, and composed of the rough auricular-systolic murmur, immediately followed by the blowing ventricular-systolic murmur." Here I am a little misinterpreted. I do not object to—in fact, I commend—the use of the term *continuous* as applied to the so-called presystolic and the undoubted mitral regurgitant murmurs. I think the term represents the fact. What I do object to is the inference that of the two murmurs thus continuous, one goes one way and one another. This argument appears to have told, if I may judge by the efforts made to escape from it. Dr. Balfour explains: "The auricular-systolic murmur runs up to, and is continuous with, the ventricular-systolic (regurgitant) murmur, in the same sense of the word that the aortic-systolic murmur may be said to run up to and be continuous with the aortic diastolic (regurgitant) murmur, and when the systolic portion of this latter murmur is rough the analogy is very complete." Does Dr. Balfour really mean this? Does he ask us to believe that the so-called presystolic murmur is no more united with the undoubted systolic than are the opposed aortic murmurs with each other? Has Dr. Balfour never heard the double aortic murmur likened to the noise of a saw, or known it to be mistaken for the double rub of pericarditis? Has he ever heard the apex combinations in question so likened, or has it ever seemed to him to resemble the noise of pericarditis? Is it not going rather too far to say, as in the passage I have quoted, that the analogy between the murmurs in question is, in certain circumstances, "very complete." This appears to present a change of front; I welcome it as indicating a weakness of position. At any

[1] See foot-note on page 782. [2] Diseases of the Heart, p. 119.

rate, on this point we are agreed—if two apex murmurs are virtually inseparable, we are no longer to call one auricular and the other ventricular. Dr. Balfour tells us, in conclusion, "that it will be seen from the foregoing that" my "quarrel is with physiology and with facts, and not merely with opinions." I really do not see it "from the foregoing," which consists chiefly of what I have referred to; but when Dr. Balfour says I quarrel with physiology and facts, does he not really mean "with physiology and facts as interpreted by Dr. Balfour"? If he means this, and he cannot well mean otherwise, I am with him.

Dr. George Johnson points to the difference in conduction between the murmur of mitral constriction and that of acknowledged regurgitation as evidence that the currents which make them are in different directions; one murmur, as is well known, is nearly limited to the apex, the other is heard at the back. The fact has often presented itself to my mind, with this as possibly its explanation. The regurgitation with the so-called presystolic is through a small hole, and necessarily of small volume; it is not likely to carry its murmur so far as the copious gush which goes through the uncontracted opening. Dr. Johnson has satisfied himself that the murmur of mitral constriction precedes the impulse of the contracting ventricle, and is therefore presystolic in rhythm. I can say nothing to this, excepting that my observations have led me to a different conclusion. It has been objected, says Dr. Johnson, that "the auricular contraction would be insufficient to cause a murmur in a constricted mitral orifice." I never said so; on the contrary, I gave examples of murmurs thus produced. But I endorsed Dr. Barclay's words, that this force was insufficient to produce "one of the loudest and roughest murmurs ever heard in disease." This opinion I adhere to. It is true, as Dr. Shearar and Dr. Johnson say, that a considerable murmur like the *bruit de diable* in the neck may be made with little force or rapidity of current, but neither is the murmur connected with anything which suggests force to the touch; it is *vox et præterea nihil;* but the "presystolic" is associated with powerful movement, as the impulse and thrill testify. Where this murmur has been intense, I have sometimes been struck after death with the small amount of hypertrophy of the auricle; not what one would have expected had the murmur been auricular. I am aware, as Dr. Johnson has pointed out, that the cardiograph has been supposed to indicate that the first movement of the ventricle is coincident with auricular contraction; but the auricular part of the movement is small, probably inappreciable except by the machine, and not likely in any circumstances to be magnified into the long and rising impulse which keeps time with the "presystolic" murmur.

I had hoped to have replied separately, as their value demanded, to all the communications which have presented views contrary to my own; I regret that this has become impracticable, but I think I have omitted no essential objection. Neither need I refer in detail to those who have concurred with me, but will be content with acknowledging in general terms the important support I have received.

To conclude, let me hold up to view a common so-called presystolic murmur which begins gradually and ends abruptly, like something which expends its force against an obstacle, a steam-engine which rolls up against buffers. Its rumbling tune is all of one sort, and I presume that no one will now maintain that the beginning and the end of it belong to contrary murmurs. It is therefore all ventricular or all auricular. If auricular, what has become of the systole of the ventricle? The action of the heart, like the Government of the Queen, must be carried on. On the auricular theory there is no time for the ventricular contraction unless this laborious piece of work is comprised within the brief knock or snap which immediately follows the movement the nature of which is in question. This is short allowance. This snap is immediately or almost immediately followed by the second sound, with which the ventricular systole obviously terminates. Assuming, on the other hand, that the tangible impulse and rolling murmur are ventricular, how well the theory holds together. The idea of ventricular contraction suits the snap which comes at its end, presuming this to be made by the shutting of the mitral valve, together with tension of the chordæ tendineæ. That the short sharp sound is of this nature is borne out, as I think I have shown, by the post-mortem appearances; it must necessarily come at the end of the ventricular systole, because the flaps are rigid and must come together only slowly and when the ventricular walls are approximated. I therefore end as I began, with the belief that the so-called presystolic murmur is one of mitral regurgitation. Dr. Gairdner allows that there are mysteries about the "presystolic" murmur as he views it. From my point of view I see nothing mysterious about it.

If I have spoken emphatically, I trust I have said nothing to imply want of respect for the great authorities whose views I have presumed to criticise. If there is any truth in what I have urged, it must add value and permanence, because it supplies explanation, to the great clinical guide which we owe chiefly to Dr. Gairdner. The points of difference must be settled by further observation rather than by argument; this belief, at least, we may all share, and may agree to address a final appeal to the independence, experience, and wisdom of the future.

I am, Sirs, yours truly,

Chesterfield-street, W., Nov. 1887. W. HOWSHIP DICKINSON.

"IS CANCER CONTAGIOUS?"

To the Editors of THE LANCET.

SIRS,—This interesting question, which THE LANCET has put before the profession, will find many ready to accept the belief, upon mere analogy, that cancer is contagious. There are those who have been for years diligently searching for the germ which may have excited the cells of a part to such excessive abnormal action; and these observers have been at times ready to state that they had procured a distinctive organism. There is something so temptingly inviting in the idea that a cancer is a human oak-gall—that what the penetrating animal diplolepsis excites in the oak may possibly have its prototype in the ravages of some minute vegetable organism in man. Moreover, the growth excited by the bacillus of tubercle gives further support to such credence. I do not profess to approach the subject from any but a clinical aspect, and I can see that a mass of evidence must be collected before any true decision can be arrived at upon such data. Experiment affords a much more promising field. It has been tried, but with little success, owing probably to difficulty of proving a suitable nidus, and perhaps, too, from the inoculations having been made with the cell results rather than with the cell causes. This, however, I would suggest to such operators: that, as cancer is a disease of age, the oldest animals procurable would probably be its most ready recipients. Since THE LANCET put the question on Oct. 8th there have been three cases published in which cancer of the womb in the wife was associated with epithelioma of the penis in the husband. It is an interesting coincidence, but we have no evidence that the cancers were of the same type. If it were shown, for instance, that in the woman the growth was a colloid cancer of the body of the uterus, would that entirely invalidate the idea of contagion when the husband's growth is known to be epitheliomatous? We now, in explaining the well-recognised heredity of tubercle, are fain to believe that in a particular type of the human species Koch's bacillus finds a peculiarly appropriate soil. Will the individual and the part attacked explain the form of cancer? Besides the three cases referred to, one of your correspondents has put forward a case of cancer of the womb in the wife associated with epithelioma of the tongue in the husband. If, however, it may come about that some one germ may produce different forms of cancer in different individuals, modified also by the part attacked, then cases occurring in persons living together will become of great interest and importance, apart from direct inoculation.

The following curious instance of three different forms of cancer, occurring in three individuals living together in the same house, may some day receive an explanation other than that of mere coincidence. In 1881, and again in 1883, I operated on a gentleman suffering from rodent ulcer of the eyelid and forehead. He is still living, but with a return of the growth. In 1884 I operated on his wife for scirrhus of the breast; and during the past week a partner, who has always lived in the same house with them, has come under my care with epithelioma of the tongue. I would not suggest that there is of necessity anything more than accidental association between these cases, but the coincidence is the more interesting in that there is no blood relationship between them. Before one has learnt to attribute the ravages of

cancer to the introduction of some external virus, one must have regard to the more apparent contributaries to its outbreak; and if asked as to these, I should give, in order, age, syphilis, melancholia, gout.

I remain, Sirs, yours truly,

R. CLEMENT LUCAS, B.S. Lond., F.R.C.S.,
November, 1887. Senior Assistant Surgeon to Guy's Hospital.

To the Editors of THE LANCET.

SIRS,—The subject of the possible contagiousness of cancer has now been discussed in your columns for several weeks, but perhaps yet another illustration of its probable occasional conveyance from one individual to another may be worthy of mention.

Some few years ago I was consulted by a married man respecting an irregular nodule which had appeared beneath Poupart's ligament on one side. This growth gradually increased and extended itself upwards into the iliac fossa, developing into an ordinary malignant tumour. The patient died at a not very distant date. There was no disease of the penis. Some few weeks later the wife of this patient consulted me for uterine symptoms of some considerable duration, and on examination I found her to be affected with extensive cancerous disease of the os uteri and vagina. She also died in due course. I had at the time, and have now, little doubt that the case was one of infection, and that the malignant groin tumour of the husband was due to absorption of the discharge from the wife's uterus; but whether through a temporary abrasion or through unbroken skin I could not tell. Such discharge doubtless contains the freed nuclei or nucleoli of the cast-off cells, and it is quite reasonable to suppose that these minute bodies may be capable of absorption under favourable circumstances, and so induce new growth in the spot where arrested.

In this respect this case would differ from those in which secondary cancer is implanted, or communicated by abiding contact with adjacent tissue, examples of which latter are occasionally seen in cancer of the peritoneum.

I am, Sirs, yours obediently,

Norwich, Nov. 8th, 1887. PETER EADE, M.D. &c.

REFORM AT THE COLLEGE OF SURGEONS.

To the Editors of THE LANCET.

SIRS,—The crowded state of the general meeting held on the 3rd inst. is one proof the more, if proof were needed, that the medical profession is fully alive to the momentous issues at stake between the Council and the great mass of the corporation of the College. The Members are showing that they feel the responsibility of their position as constituent parts of "*one body politic and corporate.*" Such a spectacle of overflowing benches can never have been even dreamt of four years ago; and yet it is less than that space of time since the pebble was first cast whose ever-widening rings of undulation have spread to the outer boundaries of this mighty sea. To yourselves the Members of the College owe a debt of gratitude for this encouraging demonstration, for without the aid of the medical press our own toil and our own efforts must have taken many a weary year in bearing fruit.

There were two special points of interests in last week's meeting that call for notice. The first, the noteworthy fact that one member of the Council, Mr. Willett, broke the accustomed statuesque repose of that group of silent figures by holding up his hand in favour of the first resolution. The second, that Sir Joseph Lister destroyed the illusion of the theatrical *mise-en-scène*, by addressing himself to the meeting; for hitherto the President alone had condescended to parley with us.

If anything, the action of the Council was more unconstitutional than usual, for, having called a general meeting of the *corporation* (we persist in calling the College by its chartered name) to receive, and presumably to discuss, its annual report, it refused to submit to the meeting the resolution sent in duly by Mr. Pollock, and maimed that of Mr. Tweedy. Moreover, the Chairman of the meeting (for every such meeting *must* have a chairman) declined to transmit a resolution carried at the meeting to the authorities to whom he was bidden by the meeting so to do. This was but another instance of the weakness of the tactics chosen by that august body, the Council of the Royal College of Surgeons of England. With a bad hand to play, it always selects the most disastrous cards to follow with, and seems blind to the consequences of insisting that clubs are trumps, whatever the turn-up card may have so far forgotten itself as to be.

We pass over for the present the magnificent way in which the Council is spending the Erasmus Wilson bequest; £50,000 seems but a trifle for it to squander, unheeding and ill-advised. But the day of reckoning must come ere long, and the Members will then demand why, in the very face of a movement destined speedily to alter the constitution of a governing body, that body makes haste to dispose of property the trust of which is drawing near its term.

However, events are now crowding towards an issue, and almost ere your journal is in the hands of the profession the Privy Council will have received (on Nov. 11th) two deputations in opposition to the form of Supplemental Charter prayed for by the Council of the College, the one deputation coming from the Fellows of the College, the other from its Members; and we may add that we have the promise of the attendance and support of two or three prominent members of Parliament, who will, should the case pass on to a still higher Court of Appeal, watch vigilantly over our interests there. The matter has passed out of the hands of the College Council now. The laity has heard of our struggle, and no longer can the voice of the Members be stifled under the pillow of obstruction.

We are, Sirs, your obedient servants,

WARWICK C. STEELE, } Hon. Secs. Assoc.
WM. ASHTON ELLIS, } M.R.C.S.

Grosvenor-road, S.W., Nov. 9th, 1887.

ON CARBOLIC ACID AS AN ANTIPYRETIC.

To the Editors of THE LANCET.

SIRS,—The important letter of Mr. Wiglesworth on the treatment of scarlet fever by carbolic acid has interested me extremely, and induces me to mention a few observations which I have lately made with the same drug, and the publication of which I have only hitherto deferred in hopes of adding to their number before taking that step.

The first case to which I shall refer, although a solitary one of its kind, appears to show that the acid is a decided and effective antipyretic. A healthy primipara was seized on the third day after delivery with rigors and pyrexia, which persisted for several days, in spite of the administration of quinine &c., and vaginal injections of solutions of carbolic acid and perchloride of mercury. On the eighth day, when the temperature in the axilla was 103·4°, I determined to apply strong carbolic glycerine (equal parts of the acid and glycerine) to the cervix uteri. A good many years ago some successful cases were described by Dr. Peter Eade, in THE LANCET, in which the cervix was smeared with this strong preparation, and I had already adopted this treatment in one previous case, which ultimately recovered. In that case, however, which occurred in the practice of a midwife, the symptoms were comparatively mild, and the application was not followed by any direct and marked effect on the temperature, and was repeated daily for a considerable time before the recovery of the patient was assured. I had little hope that an application so evanescent in its effects would be of much avail in the present case, and I determined to leave the acid in contact with the cervix for a considerable time, besides applying it to the fundus of the uterus. Accordingly, after passing an ordinary sound wrapped thickly round with cotton wool saturated with the medicament to the fundus, I left two pledgets of the same medicated cotton in the vagina and in close apposition to the cervix. These were passed through a speculum and had threads attached to them. Half an hour afterwards I was hastily summoned to see the patient, who was said to have become very weak. I found her in a state of partial collapse, with cold extremities. Pulse slow, but not weak; temperature in the axilla subnormal, —97·6° F. I instantly withdrew the plugs and administered a stimulant, and she soon rallied. It was quite clear that the carbolic acid had been absorbed in considerable quantity, and that it had exercised a decisive antipyretic action; and, further, that, like other antipyretics, it had manifested a liability to produce symptoms of collapse. Next day I found the patient comparatively cool; tempe-

rature 100·2°. I applied the medicament to the fundus and cervix as before, but did not leave any in contact with the latter. During the following two days she remained so well that I did not repeat the application, but on the third day the temperature had again risen to 103°. A cautious application to the cervix on this and the following day of only one minute's duration sufficed to check the pyrexia effectually and finally, and the patient made an excellent recovery.

Both Wood and Bartholow state that carbolic acid has been extensively used in diphtheria, scarlet fever, &c., but with disappointing results. It seems, however, to have been used only with a view to an antizymotic action, and probably in doses much too small to exercise an antipyretic influence. Both authors cite the results obtained by Emil Erls, who found that in mild putrid poisoning in animals the acid very much diminished the fever heat. After my experience of the above case, I felt a strong conviction that to produce an effective antipyretic action with the drug it was only necessary to administer it in sufficient doses. Two cases of typhoid shortly afterwards occurred in my practice, in children of one family, the first of which, however, I did not see till the case was well advanced. In the second case—a boy of fourteen years—the following notes were taken: On Aug. 3rd, several days from the commencement of the fever, the pulse was 120; respiration 28; temperature 104·6°. Ordered four grains of carbolic acid (in the form of carbolic glycerine, suitably diluted) every four hours, equal to twenty-four grains in twenty-four hours. On Aug. 5th, when the patient was next visited, and at nearly the same hour of the day as before, the temperature was 102·6°; pulse 110. On the 7th the temperature had fallen to 99·7°, and the pulse was 96. The patient had taken the acid regularly, and there was intense carboluria, the urine becoming so dark when rendered alkaline and exposed to the air that it required dilution with twice its volume of water before it became translucent in an inch test-tube. The drug was now discontinued for two days, and on the 9th the temperature had risen to 103·2°; pulse 108. He was again ordered three grains of the acid every four hours (eighteen grains in twenty-four hours), and on the 11th he felt much better, the temperature being 101·6°; pulse 94. He made a good recovery, and throughout the case he was remarkably comfortable, generally showing a tendency to somnolence after each dose of the acid, and presenting a marked contrast to his sister, who had gone through the fever before him.

Simultaneously with the above case I had under observation another boy of the same age, whose temperature, in spite of the administration of the same doses of the drug for several days, remained steadily at 103·2° and 103·4°. On examining the urine, however, there was not the slightest carboluria, and great was the surprise of patient and nurse (an indulgent sister) when I told them that the former had not taken a drop of the medicine, and that both had conspired to deceive me.

I have obtained beneficial results from the acid in other conditions attended with pyrexia, and can say that I have never seen a bad symptom from its use. In a severe case of erysipelas, with great pain and sleeplessness, it seemed to have both an anodyne and hypnotic influence, a good sleep being generally secured by a dose of five grains at bedtime. If seems to me that it would be of some importance from a scientific point of view to test more thoroughly than has yet been done the antipyretic action of carbolic acid before having recourse to the more complex substance, salol, whose efficiency in the same direction probably depends on the 38 per cent. of phenol which it contains.

I am, Sirs, yours truly.

Partick, Glasgow, Oct. 10th, 1887. ROBERT KIRK, M.D.

VENTILATION OF THE BEDS OF THE SICK.

To the Editors of THE LANCET.

SIRS,—In the Cambridge (Mass.) Hospital there is an arrangement for the ventilation of the beds not generally known; it is so effective that I wish to describe it. Beneath each bed is a ventilating tube of about eight inches diameter, fifty square inches area, leading directly through the floor to a foul air trunk, beneath which it communicates with the main ventilating chimney. About 2000 cubic feet of air an hour is thus drawn from beneath each bed. This ventilating tube is connected with the bed above by a four-inch pipe of tinned plate, with a proper cover and joints, which passes around the side or foot of the bed and into it beneath the clothing. This pipe is lengthened with one of the same size of pasteboard or other substance, a non-conductor of heat, reaching to any part of the bed. By this simple means foul air is removed as fast as formed, the bed kept free from odour, and the patient's body is no longer surrounded with contaminating gases. As the air presses inwards through the porous bed-clothing none escapes into the ward. Further, a two-inch flexible pipe is adjusted to that just described, and slipped over the hollow handle of the bed-pan when in use, carrying off odour from that also. In the same hospital similar means connect the beds in the private wards with the chimney of an ordinary fireplace, up which the pipe reaches about four feet to ensure a good draught with a moderate fire; the part in the chimney is of black iron. The advantages of such an arrangement in cases of sloughs, foul ulcers, cancers, and in fevers with frequent fæcal dejections, are obvious. It may be supposed that the passage of air through the bed would cool it too much. Practically it does not; probably the quantity of air passing is about the same as in beds ordinarily at the same temperature of the room, but in a different direction.—I am, Sirs, yours truly,

Cambridge, Massachusetts, U.S. MORRILL WYMAN, M.D.

VACCINATION.

To the Editors of THE LANCET.

SIRS,—The correspondence which appeared a few weeks since on the subject of vaccination induces me to send you a piece of evidence, which I have not seen recorded, but which, if borne out by the experience of others, forms a further proof that the protection afforded by vaccination varies in degree according to its character—namely, that a child vaccinated by one insertion can on the eighth day be further vaccinated from its single vesicle in three or more places; whereas if an attempt be made with a child having three vesicles at the same period to produce a fourth, it will not be successful. I have verified these experiments many times, under the first conditions with universal success, but always failing under the latter. One other fact worthy of mention is that, in cases in which fresh insertions are successfully made on the eighth day, the new vesicles mature a day or two earlier than in ordinary primary vaccinations, while the progress of the first vesicle towards scabbing is somewhat retarded.

I am, Sirs, yours truly,

Old-street, E.C., Nov. 7th, 1887. G. E. YARROW.

QUEEN'S COLLEGE, BIRMINGHAM.

To the Editors of THE LANCET.

SIRS,—My attention has this day been called to a paragraph in the letter of your Birmingham correspondent of Nov. 5th. From what he there says, it is obvious that the "halfpenny evening paper" to which he refers forms his sole reading, since the advertisement mentioned appeared according to general custom, in all the daily papers of this town, morning and evening, as also in the *British Medical Journal* and in your own advertiser. This misrepresentation coming from a special correspondent is quite inexcusable, and shows a very obvious animus against this College. I may add that the election of no candidate is "assured" until the council has confirmed it, as your correspondent ought, from past experience, very well to know. I trust that you will do me the favour of inserting this letter in your next issue, as the insinuations made against this College are both unfounded and unwarranted, and are likely to damage its reputation if not promptly contradicted.

I am, Sirs, yours faithfully,

BERTRAM C. A. WINDLE, M.A., M.D.,

Nov. 9th, 1887. Prof. of Anat. & Hon. Sec. Queen's Coll.

AN UNSUSPECTED DANGER.

To the Editors of THE LANCET.

SIRS,—A few days since, a lady, the head of a first-class school, showed me a large heap of filthy rags, cloth, and rubbish which had been taken from the inside of a number of bolsters and pillows, which had been unpicked for the purpose of the periodical cleaning and remaking which all

the school bedding undergoes—a laudable process, which is, unfortunately, not too common. The rubbish consisted of the most heterogeneous materials, and included portions of filthy coarse black serge, apparently parts of soldiers' old coat sleeves, pieces of dirty greasy silk dresses, old worsted braid from the borders of women's gowns, soiled linen rags, and coloured calico, even nuts and walnut shells and pieces of crinoline wire! The bedding in question was bought new a few years ago of an expensive and respectable upholsterer. The woman who was employed to do the unpicking works usually for the trade; she informed the lady that the practice of stuffing bedding &c. with dirty rubbish and rags was very general, and that few mattresses and bolsters contained only the material of which they were supposed to consist. May not this dirty and dishonest custom be—nay, is it not almost certainly—the cause of many of the mysterious and otherwise unaccountable outbreaks of infectious disease in schools and families? The practice is at once so filthy and so dangerous that it is high time public attention should be called to it, that it may be as far as possible guarded against, or, at any rate exposed.

I am Sirs, yours truly,

Folkestone, November, 1887. CHAS. E. FITZ-GERALD.

LIVERPOOL.

(From our own Correspondent.)

HOSPITAL SUNDAY AND SATURDAY.

THE annual meeting in connexion with the Hospital Sunday and Saturday collections took place on Monday, at the Town Hall, the Mayor, Sir James Poole, presiding. The committee, in their annual report, lamented a considerable decrease in the receipts compared with those of last year. The number of church and chapel collections was 312, realising £6029, against £6217 last year; the amount received in the Hospital Saturday boxes reached £2851, against £3135 last year. The amount distributed by the committee this year was £8750 in addition to £185 voted last year to the Hospital for Women, but held in abeyance; this was forwarded to the treasurer of that institution. What is much needed is greater effort on the part of the working men. By systematic and regular contributions of a halfpenny per week an enormous addition might be realised. Owing to peculiar circumstances Liverpool has felt the depression of trade probably more than any other city; this is the explanation of this decrease.

THE HOSPITAL FOR WOMEN.

The following considerable additions and improvements have lately been made in this hospital. A large operating theatre has been provided, two new wards have been opened, and a day room for patients has been furnished through the kindness of two members of the Ladies' Committee, whilst additional dormitories and a day room for nurses have materially increased the comfort of the hospital.

INTERESTING ABDOMINAL SECTION.

The following very interesting case recently occurred in the practice of Dr. Macdonald of Walton. The patient, believing herself to be six months pregnant, sent for Dr. Macdonald on account of abdominal pain and tenderness, with general prostration. Dr. Grimsdale was consulted. Both he and Dr. Macdonald, believing the source of the almost fatal hæmorrhage to be the ruptured sac of an ex-fœtation, advised operation as the only apparent chance of the patient's survival. Dr. Briggs, surgeon to the Hospital for Women and to the Lying-in Hospital, assisted by Drs. Macdonald and T. B. Grimsdale, opened the abdomen and released from among the intestines and behind the omentum a large quantity of fluid and clotted blood, which had been poured out from the upper portion of the ruptured sac. The sac contained a six months fœtus, which was removed, and both the peritoneal cavity and the sac were drained by glass tubes. The pregnancy, tubal in the first instance, had expanded the left broad ligament, and finally ruptured, at the unusually late period of the sixth month. The progress so far, up to the twenty-seventh day after operation, has been satisfactory.

THE NORTHERN HOSPITAL.

Monday was an unusually busy day at the Northern Hospital, there being, in addition to the ordinary patients, a large number of accidents, several of a very severe nature. Of the latter, one was that of a baker, who by a fall had sustained a concussion of the brain and fractured arm; a labourer falling from the roof of a house sustained a fractured thigh; and a man, seventy-one years of age, sustained a serious wound of the head, by falling from the quay into a boat. These were all taken to the hospital in an ambulance.

Liverpool, Nov. 8th.

NORTHERN COUNTIES NOTES.

(From our own Correspondent.)

NEWCASTLE COLLEGE OF MEDICINE.

THE foundation stone of the University of Durham College of Medicine was laid here on Nov. 3rd by his Grace the Duke of Northumberland, Lord-Lieutenant of the county, with the usual ceremonies. A description of the building has already appeared in THE LANCET. The luncheon, which took place afterwards in the Assembly Rooms in this city, was certainly the most important medical gathering I have ever seen in the north, and was at once a brilliant and representative meeting. Great praise is due to the committee and secretaries for the excellent arrangements made to provide for about 300 guests. The historical statement read by Mr. H. E. Armstrong on the occasion was of much interest, but must be condensed here. The first medical school in Newcastle was begun in 1832-3. The credit of this beginning is entirely due to Mr. (afterwards Sir) John Fife. After a removal to larger premises in 1834, it was recognised by the University of London and the Royal College of Surgeons of England. This school was fully equipped, and had a fairly prosperous career until it was pulled down to make way for some railway extension; so that again the school had to shift its quarters, and after some changes in its constitution it was in 1852 united to the University of Durham, and the premises known as Neville Hall became its abode. From this time the work of the College has increased greatly, as the figures show that the school of Sir John Fife's foundation has from a commencement of ten students or so recently come up to an average of two hundred. Again the demands of the railway company have turned the College out, and compelled them to erect this new building. It was mentioned that the tenure of office of the present President, Dr. Heath, as well as two members of the staff, Drs. Gibson and Gibbs, had extended over an uninterrupted period of forty years. In preparing the statement, the thanks of the College were given to Dr. Embleton, whose aid was most valuable, who had filled the position of lecturer from 1839 to 1872, and who during many years ably filled the offices of Reader in Medicine of the University and Registrar of the College. The Duke of Northumberland, the Dean of Durham, and the Mayor and Sheriff of Newcastle spoke at the luncheon, but the address of the President (Dr. Heath) was the speech of the occasion; broad, suggestive, and always eloquent, he set forth with much acumen the utility of a College of Medicine in a large community, and showed the value to the public health of proper investigations in animal pathology, and their value to the agriculturalist, and believed that the purely scientific chairs in the new College should be endowed. He pointed out in a most practical manner that what they were now doing would cost £25,000, but to complete the College to its full extent, with residential halls, would require another £25,000, or £50,000 in all. He said the College of Medicine had never hitherto asked any help from the public or from Government. It had been completely self-supporting, and now he was quite sure that his colleagues were prepared to raise upon their own responsibility a considerable sum; but he hoped that in this important matter they should not be left without some measure of support from the public. They had already had some encouragement from some of their members. They had received from Dr. Gibbs of this city the munificent donation of £1000, and he thought it only fair to say that

as Dr. Gibbs was no longer a lecturer, it made the gift the more generous, as he received no emolument from the College.

Newcastle-on-Tyne, Nov. 8th.

EDINBURGH.

(From our own Correspondent.)

THE UNIVERSITY LORD RECTORSHIP.

LAST week the Marquis of Lothian, K.T., who holds the office of Secretary for Scotland under the present Government, was elected without opposition to the post of Lord Rector of the University, in the room of the late Lord Iddesleigh. The duties of his three years' tenure of office are to preside at meetings of the University Court, to appoint an assessor to a seat at the same body, and to address the undergraduates, his constituents, at least once during the time he acts as their representative. An uncontested election for the office has been a very rare occurrence, and is in striking contrast to the active party warfare now in progress in Aberdeen University, where Mr. Goschen and Mr. John Morley are candidates for the vacant Rectorship, and in Glasgow, where the rival claims of Lord Rosebery, Lord Lytton, and Professor Max Müller are actively canvassed among the electors. Lord Lothian's unanimous election is no doubt largely due to his position as chief minister for Scotland, and to the fact that, during his tenure of the Scottish Secretaryship, he has won golden opinions from all classes of the community by the energy and ability with which he has discharged the duties of his office. As the probable author of the next Universities Bill, great things also are expected of him, and there is no doubt that his well-known moderation will give him a chance of succeeding to general satisfaction where others would inevitably fail.

PARTIAL AMPUTATIONS OF THE FOOT.

A largely attended meeting of the Medico-Chirurgical Society was held on Nov. 2nd., at which an important surgical paper was read by Mr. C. W. Cathcart, discussing the question, "Should Partial Foot Amputations be Abandoned?" As a text for his paper Mr. Cathcart exhibited two cases of partial amputation of the foot, a Chopart and a Lisfranc, along with one of amputation at the ankle joint (Syme), and commented on the marked superiority of the first two over the last in that greatest desideratum, facility of progression. As stated by Mr. Cathcart in his paper, the question seems to be narrowed to one of mechanical expediency between different schools of artificial limb makers. Mr. Cathcart has put the leading firms in the witness box by addressing them a series of questions on the subject; and as their evidence is far from unanimous, he has proceeded to investigate the whole matter *ab initio*, and has come to a conclusion wholly in favour of the partial amputations. Beginning with an account of the physiology of progression, based on the researches of the Webers and those recently published by Marey, Mr. Cathcart drew attention to the enormous value in progression of the ankle joint proper as retained in Chopart's amputation, and of the inter-tarsal joints as preserved by Lisfranc's operation—advantages to a patient of so practical a value in ensuring his stability as to outweigh completely the greater neatness claimed for the artificial foot fitted after Syme's amputation. Mr. Cathcart reiterated the dictum of the older surgeons, that where operation is performed for trauma, that method which saves the greatest extent of tissue consistent with the vitality of the stump is in every case to be emphatically preferred. After a short discussion, in which Mr. A. G. Miller and Professor John Chiene both homologated the opinions stated in his paper, Mr. Cathcart replied with a brief acknowledgment of the careful attention with which he had been heard.

THE PRESIDENT'S VALEDICTORY ADDRESS.

Professor T. Grainger Stewart then delivered his valedictory address to the Society at the close of his two years' tenure of the presidential chair. He reviewed the work done by the Society during the last two years, and took a general survey of the present position of the profession in Edinburgh. In speaking of the Medico-Chirurgical Society itself, the retiring President took occasion to note the many recent gaps in its foremost ranks occasioned by the visitations of death. In a few sympathetic sentences he spoke of the deeply lamented loss of such men as the late Dr. Angus Macdonald, Dr. Rutherford Haldane, Mr. William Brown, Dr. John Bishop, Dr. Dunsmure, Dr. Sidey, and Dr. Cumming, paying a generous tribute to the professional eminence, the geniality, and the public services of each, no less than to the loyalty with which each had striven in his own sphere to hold high the standard of professional integrity, and to assure it its high prerogative as a noble calling. In turning to review the present position of the profession in Edinburgh, Professor Stewart dealt with four aspects of the subject, each of cardinal importance. As guardians of the public health, as advisers of the general public in their most personal and private affairs, as investigators of the causes and preventives of disease, and as teachers of a rising generation of medical men—in all these relations he inquired into the present condition of the school, and though he found much ground for congratulation in the inquiry, yet on the many points where he encountered the opposite, he did not hesitate to unmask the evil and suggest measures for its reform. Professor Stewart is succeeded in the presidency of the Society by Dr. John Smith, Vice-President of the Royal College of Surgeons, and Surgeon-Dentist for Scotland to Her Majesty the Queen.

Edinburgh, Nov. 8th.

DUBLIN.

(From our own Correspondent.)

IRISH PRISONS BOARD.

DURING the year ending March last eighty-five inmates of local prisons were certified to be insane, of whom only six were considered sane on admission to the various local prisons. The medical adviser of the Board has already drawn attention to the unfavourable influence on the lunatics of their committal to prison instead of direct to the asylum. In seventy-nine out of the eighty-five of the cases admitted to local prisons during the year no reasonable doubt could be entertained respecting the insanity of the prisoners committed. The medical officers of the local prisons with justice frequently record their surprise that cases of manifest insanity should be sent to prison. The water supply of Maryborough Prison has occupied much attention during the past year. This prison stands on a somewhat lower level than that occupied by the County Infirmary, and is separated from it by a public road, while the existing arrangements in the infirmary for the disposal of excreta are not of a satisfactory character. On one occasion during the past year enteric fever occurred in Maryborough Prison and the Board's medical adviser entertained no doubt that it arose from pollution of the wells by percolation through the gravelly subsoil of water from a watercourse passing from the infirmary in the vicinity of the prison. The deaths in local prisons for the year amounted to nine, six of which were due to pneumonia. Seventy-seven prisoners were released on medical grounds, but some of the alleged causes seem trivial enough—viz., abscess of ear, hernia, enlarged cervical glands, piles, bone in throat, &c.

ROYAL COLLEGE OF SURGEONS IN IRELAND.

At a meeting of the Council held on the 3rd inst., Dr. C. H. Robinson was elected an Examiner in Physiology, to examine candidates for the Conjoint Examinations held by the College and the Apothecaries' Hall of Ireland. Dr. Hayes has been elected by the Apothecaries' Hall an Examiner in the Practice of Medicine for the Conjoint Scheme between it and the College of Surgeons.

BRITISH MEDICAL ASSOCIATION: DUBLIN MEETING.

The subscriptions to the Reception Fund of the Dublin meeting of the British Medical Association held last August, amounted to £1501 10*s.*, and the expenditure to £1442 11*s.*, leaving a balance in hand of £58 19*s.* A meeting of the subscribers will be held on Wednesday, the 9th inst., to determine how this surplus shall be disposed of.

DUBLIN HOSPITAL SUNDAY FUND.

The annual collections in aid of this Fund will take place on Sunday next, the 13th inst. Last year a sum of £4156 0*s.* 3*d.*

was collected, being a decrease of £310 5*s.* 5*d.* as compared with the year preceding. Since the establishment of the Fund in 1877 no less than £53,089 8*s.* 10*d.* has been obtained, and £49,334 2*s.* 6*d.* distributed among the various hospitals participating in it.

MEATH HOSPITAL, DUBLIN.

The introductory lecture at the opening of the winter session was delivered by Dr. A. Foot on Monday. On the same evening a dinner for the reunion of old students and governors took place at the Shelbourne Hotel, presided over by Sir George B. Owens, M.D.

ROYAL HOSPITAL, DUBLIN.

It is rumoured that this institution will shortly be closed, and a new barracks erected on the North Circular Road near the Phœnix Park.

ROYAL ACADEMY OF MEDICINE IN IRELAND.

The opening meeting of the Pathological Section of the Academy was held on the 4th inst., when Dr. Ball, the President, gave an inaugural address, in which he referred to the necessity of pathological research, and of establishing a pathological institute. Dr. Finny exhibited an hour-glass contraction of the stomach, and Dr. E. H. Bennett detailed a very interesting case of phlegmasia alba dolens, and exhibited the parts affected.

DEATH OF DR. J. VALENTINE BROWNE OF GALWAY.

An eminent surgeon, one well known in the west of Ireland (Dr. J. Valentine Browne), died last week at his residence, Prospect Hill, Galway. The deceased filled the chair of Surgery in the Queen's College, Galway, and was surgeon to the County Galway Infirmary. He was also an Examiner in Surgery in the Royal University of Ireland. He was greatly esteemed, and the utmost sympathy is felt for his family in their sad bereavement.

Mr. Henry Quinn has left £200,000 to be expended in charitable purposes in Newry.

Dublin, Nov. 8th.

BELFAST.

(From our own Correspondent.)

THE BELFAST DISTRICT LUNATIC ASYLUM.

WE understand that at their next monthly meeting a very important matter will have to be decided by the governors of this asylum. The population of the districts to which the Belfast Asylum belongs—co. Antrim, Carrickfergus, and the borough of Belfast—is about 450,000, and it is calculated that some 800 or 900 patients must be provided for in the Belfast District Lunatic Asylum. The present accommodation is, in this building, for 550. As in other parts of the kingdom, insanity has been found here to increase concurrently with the increase of the population. The question before the Board has been how to secure the additional accommodation. There are now 560 patients in the house, in addition to eighty others at Ballymena Workhouse, a sort of off-shoot of the Belfast Asylum for harmless patients. It is apparent, then, that the existing accommodation, which is for 550 patients only, at the Belfast Asylum is overtaxed, and this in the future will not be diminished. Three plans have been suggested to get out of the difficulty. It has been proposed to enlarge the asylum within its present grounds; but Dr. Nugent, Lunacy Inspector in Ireland, has reported that it would be "inexpedient to make any further additions to the Belfast Asylum, inasmuch as the number of inmates to the extent of the grounds—viz., ventilation, exercise, and occupation—would be disproportioned, and these factors, together with day-room accommodation, form an important feature in the care and treatment of the insane." Again, it has been suggested to build a new asylum to accommodate 300 patients; but to erect and furnish thoroughly such a structure would cost £30,000. A third plan is to utilise a workhouse, which might be done for £4000 or £5000. A decision will have to be made on these questions by the governors next month.

THE ROYAL UNIVERSITY.

We understand that the Royal University has recognised the Belfast Ophthalmic Hospital and the Ulster Eye, Ear, and Throat Hospital as institutions from which certificates of attendance by students will be received.

THE BRITISH DENTAL ASSOCIATION.

A meeting of the Belfast dentists was held in the Royal Hotel on Friday, under the auspices of the Irish Branch of the British Dental Association. We learn that the annual meeting of the Association is to be held in Dublin towards the end of August, 1888. The honorary secretary of the Irish Branch, Mr. Pearsall, was present at the meeting, and explained the objects and aims of the Association, and advised all who were not already members to join the Association. We understand that all present promised to do their utmost to make the meeting a success, and those who were not already members promised to join the Association.

Belfast, Nov. 8th.

EGYPT.

(From our own Correspondent.)

SANITARY DEPARTMENT.

THE work of sanitation is slowly progressing in spite of much passive resistance and an empty exchequer. During the past summer a monthly periodical called *El Safia* (Hygiene) has been started by the Government as a useful means of spreading sanitary knowledge among the native doctors. It consists of thirty-two pages of closely written Arabic character, and at present 500 copies are sold every month at 1*s.* each. It contains translations of papers from English and French journals and original articles by a committee of supporters. This publication does not in any way interfere with its native colleague, *The Cure*, which treats of matters purely medical and surgical. Five dispensaries have lately been established in provincial towns, and eight others will shortly be opened. These supply a long-felt want, and gratuitously give medicines to the poor, while the Government charges small sums to rich patients. There are now nine Englishmen in the sanitary service, all hard-working sanitary officials. It is three years and a half since the first Englishman was appointed to this department.

HEALTH OF THE BRITISH TROOPS.

The strength of the troops in Cairo and its desert suburb of Abbasiyeh is to-day 3600, with a sick-rate from all causes of 380, or 10·5 per cent. The sick are made up of 144 simple continued fever cases, 45 enteric, 13 scarlatina, and 178 venereal and other diseases. The scarlatina cases are all very mild, and include one officer, and are only of interest because the disease is very rare in Egypt. There is no evidence to show that these cases can have had the disease transmitted to them from England by letters or other articles by post. The enteric patients, like those always to be seen in this country, occur among young soldiers less than twenty-four years of age. The simple continued cases are greatly in excess of the ordinary rate, and account for the general high percentage. They come chiefly from the Welsh Regiment, which has had a sick-rate during October varying from 10·3 to 16·5 per cent. This is partly due to the regiment having previously suffered from malaria at Mauritius and the Cape of Good Hope, and partly because the Kasrel Nil barracks have been inundated by the exceptionally high Nile. The regiment has now been placed under canvas in the desert, and it is confidently expected that the fever will at once disappear. The Royal Engineers, occupying the same barracks, have had a sick-rate during October of from 5·3 to 10·1 per cent. The Cheshire and 7th Fusilier Regiments, which are in the Citadel barracks, presumably removed from all damp and malaria, have yet had sick-rates varying from 6 to 11 and from 5 to 10 per cent. The 20th Hussars, who occupy barracks at Abbasiyeh, surrounded by the healthiest desert air, have had an October sick-rate of 2·5 to 5 per cent. only. But it may be mentioned here that the Egyptian army, numbering 1500 natives, all quartered at Abbasiyeh, had only six cases of simple continued fever admitted to hospital during September, while in October the number has been raised to thirty-eight. The Cheshire Regiment is under orders for Rangoon, and will be relieved by the Rifle Brigade, who are at once to be quartered in camp on the Mokattam heights above the Citadel. In Alexandria the strength of the occu-

pying force is now 1028, with a sick-rate of 91, or 8·8 per cent. The Yorkshire Regiment there has had during October a rate between 8·3 and 11 per cent. There are now only two cases of enteric and fourteen of simple continued fever; nearly all the remainder are made up of venereal disease and prickly heat.

THE NILE INUNDATION.

Last year there was a very fairly high Nile, as judged by its maximum at Cairo, but this year it rose four feet higher, and remained at this alarming level for a whole month, beginning on Sept. 21st. It has now subsided eight feet, and is continuing to fall at the rate of more than two inches a day. The last very high Nile was in 1878, when it rose even two feet higher than this year, but on that occasion it broke its banks in several places, and only remained at its maximum for two days.

SIMPLE CONTINUED FEVER IN CAIRO.

The civilian population, both European and native, has been suffering since the middle of September from a fever, lasting from three to six days, commencing with pains in the head, back, and muscles, but not in the joints. The temperature seldom rises higher than 102°, but is occasionally seen for one night at 103°, and in very rare cases 104°. The tongue is coated white, and the bowels are undisturbed. Patients complain of nothing but lassitude, so long as they lie still, but suffer from muscular fatigue and neuralgia if they continue to work. The malaise is ushered in sometimes by vomiting, but not by rigors. The liver and spleen are not enlarged, and it is doubtful whether quinine can shorten the attack. Antipyrin relieves the feverishness and other symptoms. There is no eruption, but a few of the white patients have an erythematous flush, chiefly on the face and chest, but to be seen also on the trunk and limbs, never lasting more than two days. There have been no deaths, no relapses, no remissions, and no hæmorrhages. The weakness left by the fever is much greater than would be expected from so mild an attack. Most observers agree that there is no evidence in favour of contagion, but one Greek doctor maintains that he has seen cases of wives contracting it from husbands, and children at the breast taking the disease from their mothers. On the other hand, there are many cases of one partner of the conjugal bed not taking it from the other. The fever is undoubtedly due to excessive Nile infiltration, aided probably by the insanitary subsoil of the town's cesspools. There are no grounds for believing that this fever is analogous to dengue as known in India and America, though dengue occurred as an epidemic in Cairo in 1880, and is said to have been sporadic on the Suez Canal ever since. The fever is already abating, and does not attack recent arrivals in the country, though it has not spared those Europeans who spent the whole summer in Egypt.

Cairo, Nov. 1st.

THE SERVICES.

MR. FITCH, Surgeon on H.M.S. *Sphinx*, on the East Indian Station, has been invalided, and sent to England suffering from intermittent fever contracted recently at Kurrachee.

WAR OFFICE.—Grenadier Guards: Brigade Surgeon Arthur G. Elkington has been placed upon retired pay, with the honorary rank of Deputy Surgeon-General (dated Nov. 5th, 1887); Surgeon-Major W. R. Lane, Scots Guards, succeeds to the appointment of Principal Medical Officer of the Brigade of Guards by the retirement of Brigade Surgeon Elkington, but will retain it only until September next, as he himself will then have to retire for age.

ARMY MEDICAL STAFF.—Surgeon-Major Espine Charles Robert Ward, half-pay, has been granted retired pay (dated Oct. 28th, 1887); and Quartermaster and Honorary Captain William Amphlett Moss is granted retired pay, with the honorary rank of Major (dated Nov. 5th, 1887).

ADMIRALTY.—The following promotion has been made:—Staff Surgeon Frederick McClement, M.D., to be Fleet Surgeon in Her Majesty's Fleet (dated Oct. 25th, 1887).

RIFLE VOLUNTEERS.—1st Volunteer Battalion, the Northumberland Fusiliers:—Duncan Stewart, Gent., to be Acting Surgeon (dated Nov. 5th, 1887).

VOLUNTEER MEDICAL STAFF CORPS.—The London Division: Surgeon Adam Watson is granted the honorary rank of Surgeon-Major (dated Nov. 5th, 1887).

THE ROYAL COLLEGE OF SURGEONS OF ENGLAND.

AT an ordinary meeting of the Council of the College, held on Thursday, Nov. 10th, the Minutes of the last meeting were read and confirmed.

Two Members were removed from being Members of the College, and called upon to return their diplomas, as required by Clause 5, Section xvi., of the Bye-laws.

The appointment of Pathological Curator was deferred.

The President reported the result of the meeting of the Fellows and Members, and read the resolutions carried at the meeting (*vide* our report of the proceedings, p. 967). After the reading of the first resolution, it was proposed by Mr. Sydney Jones and seconded by Mr. O. Pemberton, "that Members of the College of a certain standing should be empowered to take part in the election of members of the Council." After discussion, Mr. Durham moved and Mr. Lawson seconded: "The previous question—that this motion be not put, and that the Council do proceed to the next business."

After the reading of the second resolution the following motion was passed:—"That the Council accede to the request contained in resolution No. 2, carried at the meeting of Fellows and Members of the College on the 3rd inst.; and in forwarding resolution No. 1, passed at the meeting, the Council desire to state that they have repeatedly and fully considered the several points mentioned in the foregoing resolution, but do not propose to ask for any change in the terms of the Charter for which they have applied to the Privy Council."

A letter was read from Mr. C. Heath resigning his appointment as member of the Court of Examiners. The resignation was accepted, and the vacancy is to be filled up at the ordinary meeting in December.

A letter was read from Mr. Wilde, reporting the transfer into the name of the College of the several stocks forming the residue of the estate of the late Sir Erasmus Wilson.

The consideration of Mr. Hutchison's motion of Aug. 4th was postponed.

Obituary.

W. F. TEEVAN, F.R.C.S., B.A. LOND.

IT is with deep regret that we chronicle the death of Mr. William Teevan at Hawkhurst, on Oct. 22nd, at the age of fifty-three. Forced suddenly—in the very prime of life and vigour of work, with fame and fortune already within his grasp—to withdraw from the ranks of his profession, he lingered for six years, awaiting the termination of a career which was as melancholy in its completion as it was brilliant in its commencement and course. Educated at University College, London, he held, after taking the Fellowship of the College of Surgeons and the B.A. Lond., the House Surgeoncy and the Assistant Demonstratorship of Anatomy to the Hospital. Joining the West London Hospital, he applied himself zealously to clinical and operative surgery. His first important publication was stamped with that thoroughness which was the characteristic mark of his after-work. It was an experimental inquiry into the causation of fractures of the skull, and his conclusions were based upon the effects of shot wounds of the skull-cap. This he published in a *brochure* entitled "The Causation, Diagnosis, and Treatment of Fractures of the Internal Tables of the Skull." Other works of an original character followed, but his appointment to St. Peter's Hospital for Urinary Disease in 1866 lent a new direction to his energy. His contributions gained for him a deservedly high opinion in the estimation of the profession, both at home and abroad, and his name and opinions are often quoted by our continental and American *confrères*. The most important are "Lithotomy," "The Dia-

gnosis and Treatment of Stricture of the Urethra," "The Treatment of Stricture, Enlarged Prostate, and Stone" (Lettsomian Lectures, 1880), and "Incontinence after Lithotomy in Children."

Whilst suffering from, and with the certain knowledge of, an incurable disease, he took an able and active part in the Medical Congress of 1881, but in 1882 aortic mischief compelled him to relinquish his practice, and he retired to Folkestone. In 1883 the terrible trial of loss of sight was superadded to his sufferings, and just before the end his reason became affected.

Mr. Teevan was ever alert to receive and to test innovations, ever ready to strike out fresh lines of practice himself, and unbiassedly to publish his results. A man is known by his surroundings, and we have often estimated the care, thought, and thoroughness of Mr. Teevan's work by examining his well-filled shelves of well-thumbed books. We have often appreciated the notes, memoirs, and apposite comments which mark Mr. Teevan's collection of the literature of urinary surgery of this century. His museum of instruments was of extreme interest. It was his hobby. It contained his failures and his successes in invention. His out-patient department had many visitors. His explanations of difficult cases were sound, terse, and lucid. His kindness to his patients was proverbial; his generosity great. Many are the tales of monetary help and kindly sympathy which have reached the ears of his co-workers. A brilliant operator, a loyal colleague, a genial friend, Mr. Teevan has passed away prematurely, leaving behind him a personality to imitate and regret.

ROBERT GREENHALGH, M.D.

DR. ROBERT GREENHALGH, whose death took place somewhat suddenly at his residence in Cavendish-square on the 7th inst., received his professional education at the Middlesex Hospital, and afterwards studied at Munich and Vienna. In 1842 he became a member of the Royal College of Surgeons of England, and in 1859 a member of the Royal College of Physicians of London, having previously, in 1853, taken the degree of M.D. at the University of St. Andrews. Some time ago Dr. Greenhalgh was compelled, through bronchial asthma and other physical ills, to retire from practice, though he saw a few old patients even within a few weeks of his decease. For many years he held the offices of Obstetric Physician and Lecturer on Midwifery at St. Bartholomew's Hospital, and also numerous honorary posts, amongst others that of Consulting Physician to the Samaritan Hospital for Women and Children. In 1844 Dr. Greenhalgh was President of the Medical Society of London.

We have received from a correspondent the following particulars of his last illness: "Dr. Greenhalgh had been at home after a recent sojourn at Tunbridge Wells for about fourteen days. During this time he had been well enough to come downstairs, and had not suffered more than was usual with him at this time of the year from his bronchial asthma. On Monday, Nov. 7th, however, his breathing became very difficult, and during the afternoon he seemed much exhausted. At 7 o'clock his dinner was taken to him in his own room, and he was able to eat some of it. He then lay down, thinking to get some sleep, and so he passed away. His daughter, who was with him, sent for Dr. Ferrier, who lived next door, and he came immediately, to find Dr. Greenhalgh dead, soon after 8 o'clock on the Monday evening."

THE LATE DR. WILSON FOX.—Mr. Francis George Heath, editor of *Illustrations*, having forwarded to Her Majesty a copy of the November issue of that magazine, containing a portrait (never before published) of the late Dr. Wilson Fox, has just received the following message from Sir Henry Ponsonby:—"I am commanded by the Queen to thank you for the copy of *Illustrations* containing the memoir and excellent portrait of Dr. Wilson Fox."

MEDICAL MAGISTRATES FOR MIDDLESEX.—William Adams, F.R.C.P., Tower Lodge, Regent's-park-road, and Maurice Davis, M.D., Brunswick-square, have been placed upon the Commission of the Peace for the County of Middlesex and the City and Liberty of Westminster.

Medical News.

ROYAL COLLEGE OF SURGEONS OF ENGLAND.—The following gentlemen, having passed the necessary examinations for the diploma of Member, were, at a meeting of the Council on the 10th inst., admitted members of the College:

*Abram, J. Hill, L.R.C.P. Lond., Carter-street, Liverpool.
*Anderson, G. Reinhardt, L.R.C.P. Lond., Westborne-villas, West Brighton.
Adams, Gerald Wheatly, L.R.C.P. Lond., Greek-st., Stockport.
Arnim, H. C. Leffler, L.R.C.P. Lond., Hinde-street.
Atkinson, Guy C. Barlow, L.S.A., Danby Parsonage, Grosmont.
Baxendell, Arthur, L.S.A., Rose Hill, Denton, Manchester.
*Bearblock, W. J., L.R.C.P. Lond., Stoke-terrace, Devonport.
Blackie, A. Babington, L.R.C.P. Lond., Blersha-road, Clapham.
*Booth, Daniel, L.R.C.P. Lond., Wall-street, Ripley, Derbyshire.
Braine, Charles Carter, L.R.C.P. Lond., Maddox-street.
*Browning, Edgar, L.R.C.P. Lond., Clarendon-sq., Leamington.
Bullock, T. Warren, L.S.A., Spring-grove, Isleworth.
*Buswell, Ferberd R., L.R.C.P. Lond., Ladbroke-grove-road.
*Campbell, H. J., L.R.C.P. Lond., Brackley, Bexley-rd., Brith.
Capes, Robert, L.R.C.P. Lond., Canbury House, Kingston.
Carnall, Edward, L.S.A., Fowey, Cornwall.
Castel, A. Leo, L.R.C.P. Lond., Osnaburgh-st., Regent's-park.
Challenor, W., L.S.A., Bismark-road, Highgate.
Cheatle, G. Lenthel, L.S.A., Vereker-road, West Kensington.
*Cole, Samuel J., L.R.C.P. Lond., Bery, Haitland, North Devon.
*Comerford, Beaumont Harry, L.R.C.P. Lond., St. George's-road.
Cotes, Digby Francis Baynes, L.S.A., Penton, Swindon, Wilts.
Daniel, E. Clement Sephton, M.B. Edin., Brampton, Hunts.
Davis, William, L.R.C.P. Lond., Manor-road, Brockley.
Dixon, C. Henry, L.R.C.P. Lond., Abingdon, Berks.
Dodd, P. Vernon, L.R.C.P. Lond., Petherton-rd., Highbury-new-pk.
Evans, W. Norman, L.R.C.P. Lond., Thurloe-road, Hampstead.
*Fawsett, Frank, L.R.C.P. Lond., Fairlight, Hampton Wick.
Finnicane, Morgan Ignatius, L.S.A., Wilton House, Southsea.
*Fisher, W., L.R.C.P. Lond., Erfurt Lodge, Greenwich,
*Gibbens, Frank Edward, L.R.C.P. Lond., Hunter-street.
Gilchrist, T. Casper, L.S.A., Victoria-street, Crewe, Cheshire.
Gilford, Hastings, L.R.C.P. Lond., Beech-grove, Redhill,
*Gimson, W. Douglas, L.R.C.P. Lond., Witham, Essex.
Goodchild, Nathaniel J., L.R.C.P. Lond., Sidney House, Highgate.
Griffiths, W. A., L.R.C.P. Lond., Redgrave-villas, Victoria-road.
*Hammersley, P. H. Vickers, L.R.C.P. Lond., Bridge House, Leek, Staffs.
Hemming, Claude Philip, L.S.A., Highfield, Bishop Waltham.
Hemming, John J., L.S.A., Concrete House, Swindon.
Hillyer, W. H., L.R.C.P. Lond., Elleralie, Balham-park-road.
Hinde, F. R. Berthon, M.B., C.M. Ed., General Hosp., Nottingham.
*Hogarth, Christopher Whewell, L.R.C.P. Lond., St. Lawrence-rd.
*James, C. Henry, L.R.C.P. Lond., St. Thomas's Hospital.
*James, Coram Llewellyn Stuart, L.R.C.P. Lond., Windsor-road, Forest-gate.
*Jarvis, J. H. E., L.R.C.P. Lond., Barron-hill-place, Ashford.
Lancaster, E. le Cronier, M.B., B.S. Oxon., Wharton-road, West Kensington-park.
*Lane, Frank, L.R.C.P. Lond., Fairholt-road, Stoke Newington.
Ledward, Milton Prentice, L.S.A., York-st., Chestham, Manchester.
Lewis, Charles Mortimer, L.R.C.P. Lond., Henfield, Sussex.
Lewis, H. W., L.R.C.P. Lond., Doddington-grove.
Littig, Lawrence W., M.D. Pennsylvania, Davenport, Iowa.
Mc Carthy, Itar Ausbert Orva, L.R.C.P. Lond., Imborough-road.
Martyn, Reginald, L.R.C.P. Lond., Falkland Park, Torquay.
*Marvin, H. F. Churton, L.R.C.P. Lond., Agate-rd., Hammersmith.
Matthews, C. E., L.R.C.P. Lond., St. Thomas's Hospital.
Morse, F. Batho, L.S.A., Gerard-street, Soho.
Mortimer, W., L.R.C.P. Lond., Richmond, Cape Colony.
*Moynihan, Berkeley G. A., L.R.C.P. Lond., Millgarth-st., Leeds.
Parker, W. Turnour, L.S.A., Lillie-road, Fulham.
Pearse, Frank, L.R.C.P. Lond., Marquess-road, Canonbury.
*Penny, Jeremiah, L.R.C.P. Lond., Combe, Crewkerne, Somerset.
Plummer, H. Beddoes Wetherell, M.B. Durh., Whitehouse, West Hartlepool.
*Reading, Richard Fairfax, L.R.C.P. Lond., Middlesex Hospital.
Richardson, Alfred Ernest, Kibworth, Leicester.
Roxburgh, Alex. Bruce, L.R.C.P. Lond., New-street.
*Selby, Prideaux George, L.R.C.P. Lond., Korolt, North-park, Croydon.
Scott, Kenneth Mackenzie, M.B., C.M. Ed., Raine-park-road, Edinburgh.
Sidebotham, Harold, L.R.C.P. Lond., Church-street, Hyde, Cheshire.
Spencer, Matthew Hy., L.R.C.P. Lond., Park-road, New-cross.
*Stiles, Theodore Mayo, L.R.C.P. Lond., Woodland Bank, Bristol.
Stocks, William Percy, L.S.A., Oldham Infirmary.
*Sully, Albert Max., L.R.C.P. Lond., The Colony, Burnham.
*Suzuki, Shigemichi, L.R.C.P. Lond., Lambeth Palace-road.
Swindles, Edgar, L.R.C.P. Lond., King's-road, Clapham-road.
Thomas, Richard Francis, L.R.C.P. Lond., Dunraven, Treherbert.
*Thompson, Walter, L.R.C.P. Lond., East Rigton, Bardsey, Leeds.
Trechmann, M. Lincoln, M.B., C.M., Norton Lodge, Stockton-on-Tees.
*Turton, Robert Straker, L.R.C.P. Lond., Halsey-street.
*Vickery, William Henry, L.R.C.P. Lond., Kingsbridge, South Devon.
Walcott, Thomas, M.B., C.M. Ed., Northumberland-street, Edinburgh.
Ward, Arthur Henry, L.R.C.P. Lond., Stafford-place.
Watkins, Frank Augustus, L.R.C.P. Lond., Stowe Park, Newport, Mon.
*Whitchurch, Henry Frederick, L.R.C.P. Lond., Chetwynd-road, Highgate-road.

* Candidates under the Regulations of the Examining Board in England.

*White, John Houghton, L.R.C.P.Lond., Welbeck-street.
Wigglesworth, Sidney, L.R.C.P.Lond., Albert-road, Southport.
*Wilde, R. Gerard, L.R.C.P.Lond., Westbourne, Emsworth, Hants.
Wright, Bernard Duncan Zorapore, L.R.C.P.Lond., Kildare-terrace.
Wright, Edmund Hasall, L.R.C.P.Lond., Springfield-road, St. John's Wood.
Wynne, Edwd. Thos., L.R.C.P.Lond., Argyle-road, Kensington.
Ziemann, Herrman Peter, Furborough-road.

* Candidates under the Regulations of the Examining Board in England.

The following gentlemen having passed the necessary examinations were at a meeting of the Council on the 10th inst. admitted Licentiates in Dental Surgery:—

Ackland, Robert, Southernhay, Exeter.
Badcock, John Henry, Tottenham-court-road.
Colyer, J. Frank, Hazeldene, Thurlow-park-road, West Dulwich.
Goard, Thomas Arthur, Portland-square, Plymouth.
Jones, Albert Sidney, Bridge House, Stamford.
Kendall, William Henry, Chapel-street, Warwick.
Miller, Frederick Tayler, Baron's-court-road, West Kensington.
Morley, Charles Reginald, London-road, Derby.
Picton, Henry, Annandale, Rossiter-road, Balham.
Saul, Barnett Bendet, Herreson, Ramsgate.
Smith, Arthur Hopewell, Lindon House, Boston, Lincolnshire.
Stoner, Harry John, Western-road, Brighton.
Wakefield, Stanley Bennett, Bevan-villas, Lower Richmond-road, Putney.

VICTORIA UNIVERSITY, MANCHESTER.—On the 4th inst. the degree of Bachelor of Medicine was conferred on the following gentlemen:—

Bury, Frederic Charles, Owens College.
Robinson, Frederick Gardner, Owens College.

NEW COTTAGE HOSPITAL.—Mr. J. W. Maclure, M.P., has decided to erect and equip a cottage hospital for Hulme.

LITERARY INTELLIGENCE.—A new work, entitled "Tätowiren: Narbenzeichnen und Körperbemalen," by W. Joest, is about to be issued in Berlin by Archer and Co.

VACCINATION GRANT.—Mr. Ernest S. Medcalf, public vaccinator, Steyning Union, Hove, has received the Government grant for successful vaccination.

HEREDITY AND NURTURE.—The proposed course of lectures by Mr. Francis Galton on this subject at the South Kensington Museum is unavoidably postponed.

EAST LONDON HOSPITAL FOR CHILDREN, SHADWELL.—The Earl of Meath has consented to take the chair at the ninth festival dinner of this charity, to be held at Willis's Rooms on Thursday, the 24th inst.

MEASLES.—An epidemic of measles prevails in several of the villages and hamlets of East Kent. At Boughton a large portion of the juvenile population are attacked.

THE DENTAL HOSPITAL OF LONDON.—The Annual Dinner of the staff and past and present students will be held on Saturday, December 3rd, at the Holborn Restaurant, under the presidency of George Gregson, Esq.

TWO deaths from hydrophobia have just occurred at Bradford. During the past two years the police authorities of that town have, under the dog regulations, destroyed more than 2000 animals.

A FRENCH photographer has shown that the light emitted by the glow-worm is possessed of actinic properties sufficient to produce a distinct photographic image of the holes in a cardboard box in which one of these animals was crawling about.

ROYAL SOCIETY.—Amongst the names recommended by the President and Council of the Royal Society for election into the Council for 1888, at the anniversary meeting on the 30th inst. are those of Sir W. Bowman, Prof. D. Ferrier, and Dr. A. Gamgee.

FORMING part of the Lord Mayor's Procession on Wednesday was a company of the Volunteer Medical Staff Corps, which, like other portions of the pageant, would have appeared to better advantage had the weather been more favourable.

SANITARY REFORM IN TURKEY.—A reduction of the sanitary dues on shipping, with certain quarantine reforms, having been decided upon in Constantinople, an international committee has been appointed to draw up the new tariff and rules.

MEDICAL SCHOLARSHIPS.—The Entrance Scholarship of £125 at St. George's Hospital Medical School, open to the sons of medical men, has been awarded to Mr. R. G. Turner. At the University College, Liverpool, the Holt Tutorial Scholarships, value £100 each, have been awarded to Mr. W. Thelwell Thomas and Mr. Randall Leigh.

THE prospectus of the forthcoming International Exhibition to be held at Brussels has been issued. The exhibits are divided into forty-nine classes, amongst which are the following:—Scientific Instruments, Medicine and Surgery, Chemistry and Allied Industries, Pharmacy, and Foods.

THE Association of Public Sanitary Inspectors entered upon the fifth year of their proceedings on the 5th inst., when a large body of members attended at the Westminster Town Hall to hear the inaugural address of Mr. Hugh Alexander, the chairman of the Council for the ensuing year.

CENTENARIANS.—On the 5th inst., Mrs. Michael of North Somercotes, Lincolnshire, attained her hundredth year, and on the same day was recorded the death of Mrs. Margaret Brace at the age of 104 years.—On the 6th inst., Mrs. Rees, living near Llandovery, celebrated her hundredth birthday.

LEAMINGTON AND WARWICK HOSPITAL.—The foundation stone of the new sanitary hospital for the Warwick Joint Hospital Board was laid at Heathcote on the 7th inst. by the Mayor of Leamington. The site contains about six acres and has cost about £1200. The hospital, which will provide accommodation for twelve patients, six of either sex, will, it is estimated, cost nearly £7000, including the necessary administration buildings.

THE UNITED GUYITE CLUB OF 1868.—The nineteenth annual meeting of this club was held at the Holborn Restaurant on Wednesday, Nov. 2nd, when Mr. G. S. Elliston of Ipswich took the chair. As next year will be the twentieth anniversary of the foundation of this club, the chairman expressed a wish, which was unanimously adopted by those present, that in 1888 every member should be present at the annual dinner, and it was further suggested that each member should bring a friend who had been educated at Guy's Hospital.

MEDICAL MAYORS.—The following members of the medical profession were elected mayors on the 9th inst.:—Alderman J. B. Stedman, Godalming; Alderman David Thompson (second time), Launceston; Alderman Clubbe, Lowestoft; Mr. W. Nettle, Liskeard; Major Adam Wilkinson, Shaftesbury; Alderman John Jones, Wrexham; Dr. Colmer, Yeovil; Mr. G. Booth, Chesterfield; Mr. William Rhodes (re-elected), Bridgnorth; Mr. J. C. Macaulay, Honiton; Alderman Samuel Farrant (re-elected), Taunton; and Mr. C. E. Baker (re-elected), Tenterden.

SMALL-POX IN SHEFFIELD.—The outbreak of small-pox in Sheffield has assumed serious proportions; as many as 100 fresh cases occur each week, and as the hospital accommodation is inadequate, it has been decided to erect temporary buildings a few miles outside Sheffield to accommodate eighty cases, these being in addition to the two existing hospitals. At the meeting of the Town Council on the 9th inst. it was decided to close the lending departments of all the free libraries in the town, to prevent the spread of the disease by means of infection brought by books.

BOOKS ETC. RECEIVED.

BARRIE, GEORGE, Philadelphia; CROSBY LOCKWOOD & SON, London.
Autobiography of Samuel D. Gross, M.D. &c. With Sketches of his Contemporaries. Edited by his Sons. In 2 Vols. pp. 407—437.

BELL & BRADFUTE, Edinburgh.
Medical Diagnosis: a Manual of Clinical Methods. By J. Graham Brown, M.D., F.R.C.P.Ed. Third Edition. pp. 350, Illustrated.

BRYCE & SON, Glasgow.
Our Children: a Guide to Mothers. By Robt. Bell, M.D. pp. 232, 2s. 6d.

CAMBRIDGE UNIVERSITY PRESS.

Elementary Chemistry. By M. M. Pattison Muir, M.A., and Charles Slater, M.A., M.B. pp. 368.

Practical Chemistry: a Course of Laboratory Work (companion work to the above). By M. M. Pattison Muir, M.A., and Douglas Carnegie, B.A. pp. 224.

CASSELL & Co., London, Paris, New York, & Melbourne.

The Natural History of Cow-pox and Vaccinal Syphilis. By Chas. Creighton, M.D. pp. 160.

CHURCHILL, J. & A., New Burlington-street, London.

Illustrations of Clinical Surgery. By Jonathan Hutchinson, F.R.S., LL.D. Fasc. XX. and XXI. 6s. 6d. each part.

Contributions to Clinical and Practical Medicine. By A. T. H. Waters, M.D., F.R.C.P.Lond. pp. 195.

The Saliva as a Test of Functional Disorders of the Liver. By Samuel Fenwick, M.D., F.R.C.P. pp. 78.

CLARENDON PRESS, Oxford.

Lectures on Bacteria. By Prof. A. De Bary. Second Edition, improved. Authorised Translation by H. E. F. Garnsey, M.A. Revised by I. B. Balfour, M.A., M.D., F.R.S. pp. 193, with 20 woodcuts.

CLOWES & SONS, Charing-cross, London.

Accidental Injuries, their Relief and Immediate Treatment. By James Cantlie, M.A., M.B., F.R.C.S. Twelfth Edition, revised and enlarged. pp. 162, Illustrated. 1s. 6d.

GILL & SONS, Warwick-lane, London.

A Complete Picture Gallery of the Animal Kingdom, in which 735 woodcuts, arranged systematically, illustrate all the Commoner Forms of Animal Life. pp. 120. 2s.

Fairy Life and Laughter. By Isabel Lawford. pp. 96, with 85 Illustrations. 3s. 6d.

KEGAN PAUL, TRENCH & Co., Paternoster-square.

Animal Magnetism. By Dr. A. Binet and Charles Féré. pp. 378. 5s.

LEUZINGER & FILHOS, Rio de Janeiro.

Atlas das Maladies de la Peau. Par le Dr. Silva Araujo. Fasc. 1, 2, and 3.

LIVINGSTONE, E. & S., Edinburgh.

The Students' Handbook of Chemistry. By H. L. Greville, F.I.C., F.C.S. Second Edition. pp. 488.

LONGMANS, GREEN, & Co., Paternoster-row, London.

The Marriage of Near Kin, considered with respect to the Laws of Nations, the Results of Experience, and the Teaching of Biology. By Alfred H. Huth. Second Edition, revised. pp. 475.

A Short Manual of Surgical Operations. By Arthur E. J. Barker, F.R.C.S. pp. 433, with 61 Illustrations. 12s. 6d.

Transactions of the Clinical Society of London. Vol. XX. pp. 377, Illustrated.

Euthanasia, or Medical Treatment in Aid of an Easy Death. By Wm. Munk, M.D., F.S.A. pp. 105. 4s. 6d.

Experimental Chemistry for Junior Students. By J. E. Reynolds, M.D., F.R.S., &c. Part IV.: Chemistry of Carbon Compounds, or Organic Chemistry. pp. 334, with Illustrations. 4s.

MARCUS WARD & Co., Farringdon-street.

Teneriffe and its Six Satellites, or the Canary Islands past and present. By Olivia M. Stone. In Two Volumes. pp. 477—457. Illustrated.

PENTLAND, YOUNG J., Edinburgh.

Medical Electricity. By Roberts Bartholow, A.M., M.D. Third Edition, enlarged and improved. pp. 304, with 110 Illustrations.

A Manual of Treatment by Massage and Methodical Muscle Exercise. By Jos. Schreiber, M.D. Translated by W. Mendelson, M.D. pp. 265, Illustrated.

A Practical Treatise on Impotence, Sterility, and Allied Disorders of the Male Sexual Organs. By Samuel W. Gross, A.M., M.D., LL.D. Third Edition, thoroughly revised. pp. 172, with 16 Illustrations.

A Compend of Human Anatomy. By S. O. L. Potter, M.A., M.D. Fourth Edition, revised and enlarged. pp. 247, with 117 Illustrations.

Maternity, Infancy, and Childhood. By J. M. Keating, M.D. pp. 321.

Outlines for the Management of Diet. By E. T. Bruen. pp. 135.

The Nursing and Care of the Nervous and the Insane. By C. K. Mills, M.D. pp. 147, Illustrated.

The Life and Recollections of Doctor Duguid of Kilwinning. Edited by J. Service, L.R.C.S. & P.Ed. pp. 287.

Manual of Clinical Diagnosis. By D. Otto Seifert and Dr. Friedrich Müller. Third Edition, revised and corrected. Translated by W. B. Canfield, A.M., M.D. pp. 173, Illustrated.

SCOTTISH TEMPERANCE LEAGUE, Glasgow.

Her Only Son. By the author of "Nelly's Dark Days." pp. 109, Illustrated.

The Adviser: a Book for Young People. pp. 104.

SHAW & SONS, Fetter-lane, London.

The Public Health Act, 1875, annotated, with an Appendix. By W. G. Lumley, LL.M., Q.C., and E. Lumley, B.A. Third Edition, with Additions, by W. Patchett, Q.C., and A. Macmorran, M.A. pp. 1303. 32s. 9d.

TREAT, R. B., New York.

A Practical Treatise on Diseases of the Hair and Scalp. By G. T. Jackson, M.D. pp. 356, with Illustrations. $2.75.

A System of Gynecology. By American Authors. Edited by Matthew D. Mann, A.M., M.D. Vol. I. pp. 789, with 3 coloured and 201 Engravings.

TRÜBNER & Co., Ludgate-hill, London.

A Short Practical Treatise on the Nature, Causes, and Treatment of Cholera. By Deputy Surg.-General H. W. Bellew, C.S.I. pp. 204.

Women and Work. By Emily Pfeiffer. pp. 186.

Alassio: a Pearl of the Riviera. By Dr. Jos. Schneer. pp. 80.

Cholera and Water in India; by M. C. Furnell, M.D., F.R.C.S. (Churchills).—Grand Canary as a Health Resort; by Mordey Douglas, L.R.C.P., &c. (Churchills).—Digestion and Indigestion; by De Quintin. 2s. 6d.—The Ambulance Pupil (Crosby Lockwood & Co.).—The Otophone; by J. A. Maloney, D.C.—The Horse in Sickness, and how to Treat him; by John Cockram (Upcott Gill).—Report of the Chapter of the Order of St. John of Jerusalem, 1887.—Transactions of the Medical and Chirurgical Faculty of the State of Maryland, 80th Session. Des Progrès accomplis sur la question de la Rage; par le Dr. Duboué (Masson, Paris).—Ueber die antiseptische Wirkung des Iodoforms; von Dr. M. T. Schnirer.—How to Play the Fiddle; Second Edition; by H. W. and G. Gresswell.—The English Meat Supply; by A Farmer (Bates, Grace-church-street). 3d.—Index Medicus, Vol. IX., No. 9.—A Letter to the Right Hon. Lord Aberdare, Chairman of the Managing Committee of the Hospital for Sick Children; by Charles West, M.D.—Surgical Relations of the Ileo-cæcal Region; by J. Mc F. Gaston, M.D.—Story of a Blind Mute; by C. Macculloch (Gemmell, Edinburgh).—A Note on Indo-European Phonology; by D. B. Murdoch, L.R.C.P., &c. (Trübner, London). — Magazines for November: Good Words (with Christmas Number, "While Golden Sleep doth Reign"); Sunday Magazine (with Christmas Number, "Little Snow Flakes"); Leisure Hour, Sunday at Home, Boys' Own Paper, Girls' Own Paper, Scribner's Monthly.—The American Journal.—Histoire des Progrès de la Laryngologie; par Dr. Gordon Holmes; traduit par le Dr. Calmettes. —Die Geschichte der Laryngologie; von Dr. Gordon Holmes; aus dem Englischen übersetz von Dr. Otto Koerner.—La Responsabilità del Governo nella Salute Pubblica. — Notes on Dental Surgery; by J. Smith, M.D., LL.D. (Maclachlan and Stewart, Edinburgh).

Births, Marriages, and Deaths.

BIRTHS.

BULL.—On the 7th inst., at St. Oswald's House, Stony Stratford, the wife of Wm. H. Bull, F.R.C.S., of a daughter.

CRAWFORD.—On the 2nd inst., at St. John's-park, Blackheath, the wife of Sir Thomas Crawford, K.C.B., Director-General, Army Medical Department, of a son.

LAMB.—On the 15th ult., at River View, Ashton-on-Ribble, Lancs., the wife of Hugh Lamb, M.R.C.S., L.R.C.P.Lond., of a son.

MORRIS.—On the 9th inst., at Gordon Lodge, Charlton-road, Blackheath, S.E., the wife of Clarke J. Morris, M.R.C.S., of twin daughters.

TEACHER.—On the 29th ult., at 5, Newington-road, Edinburgh, the wife of Charles C. Teacher, M.B., C.M., of a son.

WARBURTON.—On the 31st ult., at Wiesbaden, the wife of G. A. Warburton, M.D., of a son.

WIGMORE.—On the 31st ult., at Twerton-on-Avon, Bath, the wife of J. Wigmore, M.D., of a son.

MARRIAGES.

COLET—MACLEAN.—On the 2nd inst., at Bombay, by the Rev. Dr. Mackichan, of the Free Church College, Clement C. Colet, M.B., M.S., Professor of Physiology in the Medical College, Lahore, to Mary MacLean, of Heathfield House, Hampstead-heath.

DAVIES—LLEWELLYN.—On the 1st inst., at St. Paul's, Burdett-road, Hughes Reid Davies, L.R.C.P., M.R.C.S., to Edith Amie, elder daughter of Dr. Evan Llewellyn, of The Limes, Bow.

TAYLER—RODWAY.—On the 2nd inst., at St. Mark's Church, Bath, George Christopher Tayler, M.D., to Maria Louisa, eldest daughter of the Rev. E. J. Rodway, of Weston-super-Mare.

DEATHS.

BROWNE.—On the 30th ult., at his residence, Heathwood, Leighton-Buzzard, William Browne, M.D., late of The Friary, Lichfield.

GREENHALGH.—On the 7th inst., at Cavendish-square, Robt. Greenhalgh, M.D. (late of Grosvenor-street), in his 69th year.

HALE.—On the 2nd inst., at Cavendish-place, Brighton, Robt. Douglas Hale, M.D., aged 71.

JACKMAN.—On the 2nd inst., at 114, Brixton-hill, William Thomas Jackman, M.R.C.S., &c., eldest son of Thomas S. H. Jackman, L.R.C.P.Lond., of Stoke Newington, N., in his 34th year.

PITT.—On the 27th ult., at London, William Pitt, Surgeon-Major, Bengal Army, retired list, aged 72.

N.B.—*A fee of 5s. is charged for the Insertion of Notices of Births, Marriages, and Deaths.*

Appointments.

Successful applicants for Vacancies, Secretaries of Public Institutions, and others possessing information suitable for this column are invited to forward it to THE LANCET *Office, directed to the Sub-Editor, not later than 9 o'clock on the Thursday morning of each week for publication in the next number.*

ANNACKER, ERNEST, M.D. Berlin, M.R.C.S., L.R.C.P.Lond., has been appointed House-Surgeon and Resident Obstetric Assistant Surgeon to St. Mary's Hospital for Women, Manchester, vice Donald, resigned.

CARLETON-JONES, GUY, M.R.C.S., has been appointed Assistant House-Accoucheur to King's College Hospital.

CARTER, R. T., M.R.C.S., L.S.A., has been appointed House-Surgeon to King's College Hospital.

CHEATLE, G. L., M.R.C.S., L.S.A., has been appointed House-Surgeon to King's College Hospital.

CHILCOTT, ARTHUR B., M.R.C.S., has been appointed House-Surgeon to St. Mark's Hospital, City-road.

EWENS, G. F. W., M.B., M.R.C.S., L.R.C.P., has been appointed Ophthalmic Clinical Assistant to King's College Hospital.

GIBBARD, T. W., M.R.C.S., L.S.A., has been appointed House-Surgeon to King's College Hospital.

GRIFFITHS, WALTER S. A., M.B., F.R.C.S., M.R.C.P., has been appointed Obstetric Physician to In-patients at the Great Northern Central Hospital, vice G. C. P. Murray, M.D., deceased.

HENSLEY, A. E., M.R.C.S., L.S.A., has been appointed House-Physician to King's College Hospital.

JACKSON, ALLAN HESLOP, M.R.C.S., L.R.C.P.Ed., has been appointed Medical Officer to the Lowestoft Hospital.

PHILLIPS, EDWARD ENGLAND, L.R.C.P. Ed., M.R.C.S., has been re-appointed Medical Officer of Health for the Rochford Rural Sanitary District, Essex.

RILEY, ROWLAND J., has been appointed Obstetric and Ophthalmic House-Surgeon to the Queen's Hospital, Birmingham, vice M. W. Oldham, L.R.C.P.Lond., M.R.C.S.

SHANN, WILLIAM ARTHUR, M.B.Cantab., M.R.C.S., L.R.C.P.Lond., has been appointed Medical Officer to the Lowestoft Hospital.

SMART, WM. HERBERT, M.A. Cantab., M.B., M.R.C.S., has been appointed House-Surgeon to the Royal Hants County Hospital, Winchester, vice C. Ewart, resigned.

STEPHENS, R. I., L.S.A., has been appointed Physician Accoucheur's Assistant to King's College Hospital.

WALFORD, EDWARD, M.D. Univ. Dur., S. Sc. Cert. Cantab., has been appointed Medical Officer of Health for the Cardiff Urban and Port Sanitary Districts, vice Paine, resigned.

WALTERS, F. R., M.D., B.S.Lond., F.R.C.S.Eng., has been appointed Physician to the North London Consumption Hospital.

WARD, H. P., M.R.C.S., L.S.A., has been appointed Assistant House-Physician to King's College Hospital.

WARE, GEORGE STEPHEN, M.R.C.S., L.R.C.P., L.S.A., formerly House-Surgeon, has been appointed Casualty House-Surgeon to the Middlesex Hospital.

Vacancies.

In compliance with the desire of numerous subscribers, it has been decided to resume the publication under this head of brief particulars of the various Vacancies which are announced in our advertising columns. For further information regarding each vacancy reference should be made to the advertisement.

BOLTON INFIRMARY AND DISPENSARY.—Junior House-Surgeon. Salary £120 per annum, increasing by £10 per annum to £150, with furnished apartments, board, and attendance.

BOROUGH OF SHEFFIELD.—Medical Officer of Health. Salary £500 per annum.

BOSCOMBE PROVIDENT INFIRMARY, Bournemouth. — Resident Medical Officer. Salary £60 per annum, with board and residence.

HANGLETON HOSPITAL, HOVE.—Medical Superintendent. Salary £50 a year, with additional fees.

LINCOLN COUNTY HOSPITAL.—House-Surgeon. Salary £100 per annum, with board, lodging, and washing.

LIVERPOOL DISPENSARIES.—Assistant Surgeon. Salary £80 per annum, with apartments, board, and attendance.

NATIONAL HOSPITAL FOR THE PARALYSED AND EPILEPTIC, Queen-square, Bloomsbury.—Physician for Out-patients.

PARISH OF LIVERPOOL.—Assistant Medical Officer for the Workhouse, Brownlow-hill. Salary £80 per annum, with apartments, rations, and additional sum of £20 for examining applicants for out-door relief.

PARISH OF ST. MARY, Islington.—District Medical Officer. Salary £100 per annum, with such extra medical fees as are defined by the Orders of the Local Government Board.

ROYAL ALBERT ASYLUM FOR IDIOTS AND IMBECILES OF THE NORTHERN COUNTIES, Lancaster.—Assistant Medical Officer. Salary £120 per annum, rising £10 annually to £150, with board, apartments, and washing.

ROYAL WESTMINSTER OPHTHALMIC HOSPITAL, King William-street, Strand, W.C.—Assistant Surgeon.

THRAPSTON UNION.—Medical Officer. Salary £50 per annum, exclusive of medical extras and vaccination fees.

WALLASEY DISPENSARY.—House-Surgeon. Salary £120 per annum, with furnished apartments, coals, and gas.

WESTERN GENERAL DISPENSARY, Marylebone-road, N.W. — Honorary Dental Surgeon.

METEOROLOGICAL READINGS.

(Taken daily at 8.30 a.m. by Steward's Instruments.)

THE LANCET Office, November 10th, 1887.

Date.	Barometer reduced to Sea Level and 32° F.	Direction of Wind.	Dry Bulb.	Wet Bulb.	Solar Radia in Vacuo.	Max. Temp. Shade.	Min. Temp	Rain fall.	Remarks at 8.30 A.M.
Nov. 4	29·93	S.W.	49	46	83	57	45	·02	Fine
,, 5	29·54	W.	42	41	...	52	40	·14	Foggy
,, 6	29·41	S.W.	51	48	82	54	41	·20	Fine
,, 7	29·49	N.E.	45	44	...	51	42	...	Hazy
,, 8	29·78	E.	50	48	65	52	45	·31	Overcast
,, 9	29·95	E.	49	48	...	49	47	·15	Raining
,, 10	29·84	E.	47	46	...	49	46	·41	Overcast

Notes, Short Comments, & Answers to Correspondents.

It is especially requested that early intelligence of local events having a medical interest, or which it is desirable to bring under the notice of the profession, may be sent direct to this Office.

All communications relating to the editorial business of the journal must be addressed "To the Editors."

Lectures, original articles, and reports should be written on one side only of the paper.

Letters, whether intended for insertion or for private information, must be authenticated by the names and addresses of their writers, not necessarily for publication.

We cannot prescribe or recommend practitioners.

Local papers containing reports or news-paragraphs should be marked and addressed to the Sub-Editor.

Letters relating to the publication, sale, and advertising departments of THE LANCET *to be addressed "to the Publisher."*

We cannot undertake to return MSS. not used.

MEDICAL OFFICERS OF HEALTH AND GENERAL PRACTITIONERS.

Dr. Stewart.—A medical officer of health has no right in virtue of his office to visit patients suffering from infectious or other diseases, unless with the consent of the patients, or of those who represent them during their illness. There are occasions when it may be most desirable, and even necessary, for a medical officer of health to visit a patient, in order that he may advise his authority correctly; but these occasions are not ordinary ones, and when they arise it is of the utmost importance, both for the maintenance of the proper status of his office and the credit of his profession, that he should act in harmony with the medical attendants of the sick, on whom he is also necessarily dependent for valuable assistance. The current duty of a medical officer of health in the case of infectious sickness does not involve examination of the patient; it can be performed by accepting the diagnosis of the medical attendant, and by then seeking to discover the local circumstances favouring the sickness, and advising as to the best means of prevention.

A CORRESPONDENT, whose signature is undecipherable, but which appears like "*E. A. Stanford*," is referred to a paragraph in our last issue.

Mr. Lambert.—If samples be forwarded, they will have attention in the usual way.

SYPHILIS FOLLOWING TATTOOING.

To the Editors of THE LANCET.

SIRS,—At page 911 of your last issue, Mr. Grenville Moffat states, with reference to several cases of syphilitic infection following the operation of tattooing, "the only reference to this subject that I have been able to find is in Lancereaux's treatise &c." To those interested I would beg to point to Sections 1040; 6 of both Medical Digest and Appendix, where several cases are noted; one paper published in THE LANCET nine or ten years ago, recording fourteen victims of syphilitic infection occurring in the practice of a celebrated tattooer.

I am, Sirs, your truly,

Boundary-road, N., Nov. 5th, 1887. RICHARD NEALE, M.D.Lond.

*** Much time and some of our space would often be saved if correspondents would consult Dr. Neale's valuable Digest in reference to the occurrence or record of pathological events.—ED. L.

COTTAGE HOSPITALS.

To the Editors of THE LANCET.

SIRS,—Will any of your readers kindly inform me where I can obtain copies of the rules of cottage hospitals, which I require as a model.

I am, Sirs, yours truly,

Great Yarmouth, Nov. 5th, 1887. ARTHUR WM. BLAKE, M.I.N.A.

THE GROWTH OF THE COCA TREE IN ASSAM.

THE *Monthly Magazine of Pharmacy* is informed by Mr. J. Buckingham, of Amgooria, Assam, who is now making a set of experiments on coca growing on his plantations, that the plants are all healthy, and have borne berries. He has gathered a small quantity of the leaves, and has had them dried and prepared like tea-leaves are for the market. This news is not unsatisfactory, as it is understood that at Darjeeling, where Mr. Hamstead of Seeyok and other planters have endeavoured to raise coca plants, the experiments have all resulted in failure, and this is generally attributed to the fact of the climate being too cold at certain periods of the year. It is quite possible that coca leaves raised in the East Indies, the plant being a native of the West Indies, may not possess the same valuable properties as those now used for the extraction of cocaine, but the experiment was certainly justifiable after the experience gained with regard to the cinchona tree, also transplanted from the West to the East, and yielding abundance of alkaloids in the Nilgheery Hills, if not elsewhere.

Alpha.—We think our correspondent can only recover against the person who requested his services; but he had better consult a solicitor.

C. E. M.—We cannot take the responsibility of recommending any particular work of a legal nature.

Mr. J. Abbott.—The address of the hon. secretary, Mr. A. G. Bateman, is 67, Longridge-road, S.W.

THE LOCAL APPLICATION OF CONDY'S FLUID IN SYPHILITIC GLOSSITIS.

To the Editors of THE LANCET.

SIRS,—The following case will perhaps prove interesting to readers of THE LANCET.

I was summoned to attend a man apparently about the middle period of life who presented the following appearance:—The lips were much swollen, and the mouth was quite full of a red ulcerated mass (from which unhealthy, malodorous pus was oozing), which on inspection proved to be his tongue. He was barely able to speak, and could with great difficulty swallow small quantities of liquid only. On closer examination I detected several deep fissures both on the under surface and dorsum, having indurated edges from half a line to a line in breadth. Offensive pus was welling up from the bottom of these fissures. One extended from within half an inch of the tip of the tongue for an inch and a half backwards, being nearly three-quarters of an inch deep. Another, on the right side, near the edge, ran parallel with the first, but was not so long or deep. A third extended downwards and backwards from the left side to the under surface. There were others smaller, some evidently healing, and more just beginning to ulcerate. The man complained of pain and soreness over the whole of the tongue and neck, but I could find no evidence of glandular involvement. He also suffered from "dyspepsia tonique," but was otherwise quite healthy. He informed me that he had been under several medical men, who invariably prescribed mercurials with tonics and applied solid nitrate of silver to the ulcers (some even recommended removal of a portion of the organ). This line of treatment was usually followed by alleviation of pain after some time and reduction of size, the fissures gradually lessening in number and extent, but no cure or permanent improvement. I prescribed Condy's fluid as a lotion, directing the patient to wash out the oral cavity every four hours with it, and gave the usual stomachic remedies. I called again in two days, and was much gratified to find the tongue appreciably diminished in size, the pus no longer offensive, but lessened in quantity, and that the patient could swallow fluids with greater ease. After an equal interval the patient felt much better; the dyspepsia was relieved, and at the end of ten days I noticed some of the fissures beginning to close, and could find no fresh ones. In three weeks all the fissures had healed, except the large central one and the one going downwards towards the under surface. These were, however, greatly reduced in size and depth, there being no marginal induration. At the end of two months he considered himself cured, and stopped the lotion, but in a fortnight after had to apply to me again, as an ulcer was beginning to appear far back at the root of the tongue. I ordered the same remedy as before, with like satisfactory result. He now always uses the lotion whenever any prodromal symptoms, such as pain or tumefaction, warn him. There has been no relapse for the past eight months. For diet I gave as much new milk as he could take, also meat juice, with one bottle of stout per day. I wish to add that I ceased to administer medicine of any sort after subduing the gastric trouble, though there was an obscure history of primary hard sore, but no secondaries, some fifteen years before.

I am, Sirs, yours faithfully,

Ferns, Co. Wexford, October, 1887. G. GREENE.

ETHER IN MIDWIFERY PRACTICE.

To the Editors of THE LANCET.

SIRS,—It fell to the lot of Dr. Rumboll and myself to deliver a primipara, aged thirty-four, by forceps after a ten hours' labour, during which much chloroform and ether were given. The child was apparently lifeless. Artificial respiration was kept up perseveringly by Dr. Rumboll, and the thorax was sharply slapped and sprinkled with hot and cold water, but with little result. We then injected ether subcutaneously, and improvement commenced. I do not see this use of ether mentioned in the midwifery books at my disposal.—I am, Sirs, yours truly,

Melksham, Nov. 2nd, 1887. S. GROSE.

WANT OF AN ASYLUM FOR INCURABLES IN LYONS.

DR. AUGAGNER of Lyons, editor of *La Province Médicale*, pleads for the establishment, by the local authorities, of a hospital or asylum for incurable cases, especially those suffering from cancer where an operation is impossible. He points out the miserable condition of such persons, who are necessarily discharged from ordinary hospitals after a few days' stay, these institutions being, of course, bound to reserve their beds for patients for whom something can be done. On going over the registers of the male patients of the Hôtel Dieu in 1886, Dr. Augagner found that 97 of a total of 6009, or 1·61 per cent., had been discharged as suffering from incurable cancer after a stay in hospital of from one to twenty-four days. Some few of these poor creatures are provided for by charitable religious institutions; but though the blind and the insane, and some other classes of incurables, have asylums to which they can go, the cancerous, who are perhaps the most to be pitied, have scarcely any refuge, and something more is, Dr. Augagner thinks, incumbent on the authorities than a small contribution to one of the charitable institutions alluded to, which is all that as yet they have been persuaded to grant.

Mr. John Wood.—It is not professional to advertise in the way described the price of advice and medicine either in one possessed of the qualifications of the Edinburgh corporations or of any other medical authority. Common law does not regulate professional conduct, but the bye-laws of the respective professional corporations.

Mr. J. Newlands Maclean.—It is usual to get 10*s.* 6*d.* for each attendance at the police-court. At each police-court there is usually a scale of fees, including medical fees, drawn up according to the instructions of the Home Secretary, by reason of the statutory power he possesses. Our correspondent cannot recover "unavoidable expenses" whilst attending assize.

F.R.C.S. & L.R.C.P.—The corps no longer exists. It was disbanded some years ago, and a local mounted police raised to replace it, the appointments to which are made by the governor.

PASSAGE OF FOREIGN BODIES THROUGH THE ALIMENTARY TRACT.

To the Editors of THE LANCET.

SIRS,—Several communications having been recently made to THE LANCET respecting the passage of foreign bodies through the alimentary tract, I think the under-mentioned case, which has lately been under my observation, possesses sufficient interest to be also recorded.

In June last a child, aged two years and a half, whilst playing with money, swallowed a shilling, and as it lodged in the throat the father endeavoured to get it back by the aid of his fingers; but failing to do so, he made use of a reverse method of treatment, managing to push it down with his index-finger, and a constant look-out for the passage of the foreign body was kept up. The shilling was not, however, passed, and four months elapsed, during which time the child became thinner, was irritable, and subject to many attacks of vomiting and bleeding at the nose. In October he had a violent attack after a meal, and with it brought up the lost shilling, which was much discoloured and corroded. From that day the child has rapidly regained its usual health and strength.

I am, Sirs, faithfully yours,

Wisbech, Nov. 8th, 1887. WILLIAM GROOM, M.D. Cantab., &c.

"POISONING FROM THE USE OF SUBLIMATE SOLUTIONS."

To the Editors of THE LANCET.

SIRS,—In his third post-graduate lecture on "Practical Legal Medicine" Mr. Pepper in his concluding remarks wishes to draw attention "to a source of danger to life which, so far as I know, has not hitherto been noticed in the medical press. I refer to poisoning from the use of perchloride of mercury in the form of very weak solutions—e.g., 1 in 1500 or 2000." I would venture to draw Mr. Pepper's attention to a very able and interesting article read by Dr. Dakin before the Obstetrical Society of London on Dec. 1st, 1886, in which the author draws attention to the dangers of mercurialism in lying-in women. The article, which is entitled "Mercurialism in Lying-in Women undergoing Sublimate Irrigation," appears in full in the Obstetrical Transactions for the year 1886, vol. xxviii., pp. 281–307, while an abstract of the same appears in THE LANCET of Dec. 11th, 1886. The original article in the Obstetrical Transactions is well worth the careful perusal of all who are not acquainted with it, as it is, I venture to believe, a most valuable contribution to our knowledge of the subject.

I am, Sirs, your obedient servant,

Nov. 9th, 1887. H. T. R.

WATER-TIGHT CASES.

To the Editors of THE LANCET.

SIRS,—Messrs. Arnold and Sons are evidently not aware that their "new" invention, described in your pages of Nov. 5th—viz., water-tight cases—was made by us, and exhibited at the Philadelphia Exhibition, 1876, and for which we obtained a medal. Our case, however, is superior to Messrs. Arnold's, in that the projecting tongue is made of cork, which, being pressed into the groove, makes a much better joint than two pieces of metal can possibly do.—We are, Sirs, yours truly,

Great Portland-street, W., Nov. 5th, 1887. MAYER AND MELTZER.

THE LATE EDWARD THRING, M.A., AND THE OUTBREAK OF TYPHOID FEVER IN UPPINGHAM SCHOOL, 1875.

MR. ALFRED HAVILAND, in reference to an article which appeared in our issue of the 22nd ult., states that the fever first broke out in the school, and that it was not until thirty cases, with three deaths, had occurred amongst the boys that the disease appeared in the town. Mr. Haviland also states that it was owing to his objection that the school did not return to Uppingham immediately after the outbreak was checked.

Endymion.—Yes, fairly strict. Under the circumstances described, it is very probable our correspondent would not be passed.

Mr. Maule.—No.

"SEA-SICKNESS."

To the Editors of THE LANCET.

SIRS,—In the numerous able articles which have appeared in THE LANCET lately on the above subject, I notice that an occasional feature of the evil is not noticed—viz., diarrhœa. During my experience at sea I met with three cases in which this was the prominent symptom, being unaccompanied by vomiting, although there was the usual vertigo, &c.

The first case was that of a chief engineer of long standing, who invariably in very rough weather suffered from a feeling of malaise with slight watery diarrhœa, which ceased with the bad weather. His appetite was good, urine rather lessened in quantity and clear. The only drug which had any effect on the diarrhœa was belladonna in large doses. His bowels were quite regular at other times.

The second case was a gentleman, aged twenty-five, who suffered from profuse watery diarrhœa with loss of appetite and a feeling of general depression whenever the sea was at all rough; no vomiting. Drugs were of no use.

The third case was a lady, aged thirty-three, single, who suffered so much from looseness of the bowels on any more than ordinary motion of the vessel as to be confined to her cabin for the greater part of the voyage (nearly two months). She was quite prostrate during each attack, took no food, and felt great dizziness on attempting to rise. Respiration was accelerated (about 20). She had no vomiting, and off the ship enjoyed good health. She was relieved by effervescing drinks (champagne), and was kept on a light diet when able to eat at all. Astringents had no effect, bromide of potassium seeming to be most useful. In port or during very calm weather she was quite well.

I think the theory of the churning motion of food in the stomach causing the attacks of vomiting is untenable: for (1) we get vomiting when the person has taken no food for some time before the attack; (2) a full stomach often stops the vomiting; (3) the continuance of the vomiting long after the stomach is empty; (4) the occurrence of vomiting in a perfect calm, and, as you mentioned in an able leader in THE LANCET of the 29th ult., the cases occurring before the vessel starts; and (5) cases in which the vomiting comes on without any sensations referable to the stomach at all—i.e., purely cerebral vomiting, several cases of which came under my notice, the affected persons having a good appetite and feeling quite well, with the exception of the sudden painless attacks of vomiting, which came on in bad weather at any time, lasting generally only a few minutes, and the ejected matter being, except after a meal, only colourless fluid. My theory is that sea-sickness is due to an unstable condition of the brain cells, chiefly affecting the neighbourhood of the vomiting centre in the medulla, and generally accompanied by hyper-vascularity of the brain. How this is caused by the ship's motion, and to what extent it is affected by the mental condition of the affected person, I will not attempt to explain. But the facts that the vomiting centre in the medulla, which transmits its impulses to the stomach, mainly by vagi and splanchnics, is in close relation to the respiratory centre; that we generally, if not always, find the respiratory movements increased in frequency during the attack; that we have generally increased blood supply to brain, as evidenced by throbbing of carotids, &c.; that the premonitory symptoms are usually vertigo, dizziness, &c., in a greater or less degree; and that all drugs which have any effect on the sickness are either cerebral or vascular sedatives—seem to point to the above theory being correct.

The cases of diarrhœa I ascribe to brain impulses passing to Auerbach's plexus (which governs the motion of the intestine), Meissner's plexus (which governs the secretion), and to the splanchnics (which greatly regulate the vascular supply of the intestine), and altering their normal functions.

As to treatment, I found no drug a specific, each case requiring treatment on its own merits. The only remedies which seemed universally applicable being rest in the recumbent posture (head to bow of vessel if possible), plenty of liquid, easily digested food, when it could be taken, and the free use of effervescing drinks (such as champagne).

I am, Sirs, yours truly,

R. MUSGRAVE WHITHAM, M.B. Ed.,
November, 1887. Late Surgeon, Ocean Steamship Company.

To the Editors of THE LANCET.

SIRS,—On reading the article on sea-sickness in your issue for Oct. 29th, I was reminded of a letter I had seen some time ago in one of the medical journals, in which the writer gave it as his opinion that the sea-sickness was caused by the movement of the boat throwing the intestines forward against the abdominal wall, and thereby suddenly stretching the sympathetic nerves. I do not see this particularly mentioned as one of the causes you give. It seems to me, however, a very plausible theory; for that position which is most favourable for a person to assume to prevent sickness—viz., lying on the back—is one which would, by causing the stomach and intestines to rest on the posterior wall of the abdomen, hinder any tension being put upon the sympathetics. I have known many people subject to sickness who could make a short passage by sea and avoid sickness during the voyage by lying all the time on the back. There are people also who feel sick when riding in a carriage with their backs to the horses, or seated the same way in a train; and I think it likely this may be explained by the above theory. Again, it is not improbable that the good effects of cocaine and the bromides may arise from their sedative action on the sympathetic system.

I am, Sirs, your obedient servant,
Banstead, Nov. 1st, 1887. WILLIAM HADGOOD.

"ANTIPYRIN IN MIGRAINE."

To the Editors of THE LANCET.

SIRS,—I am glad Dr. Berthold has alluded to the great value of antipyrin in migraine. My attention was first directed to this use of the drug by a paper by Professor Khomyarkoff and Dr. L'voff which appeared in the *Vrach* of Dec. 19th, 1885 (see abstract in THE LANCET of Jan. 30th, 1886); and, as far as I know, the credit of first suggesting antipyrin for the cure of migraine belongs to these Russian physicians. Since that time I have employed it with very great, though not invariable, success. Sometimes the first dose of fifteen grains has acted "like magic" within twenty minutes. In one inveterate case of periodically recurring migraine where the pain affected a single spot on the right parietal bone, the scalp over which used to become very tender, I was able for many months to give up morphia injections, antipyrin arresting the attacks almost entirely. In this case, however, there have been one or two attacks which no amount of antipyrin would relieve. In other cephalalgias which cannot be described as migraine, I have found antipyrin useful. Its employment in headaches and neuralgias due to ophthalmic affections was pointed out by Dr. Katsauroff (*Vrach*, No. 7, 1886; also see THE LANCET, April 10th, 1886). In many headaches of nervous, and in some which appeared to be of rheumatic origin, I have found antifebrine or acetanilide, in doses of from five grains to ten grains, very effective. I have not, however, been able to satisfy myself that it equal to antipyrin in true migraine. It would be of advantage if it were so, as it is far cheaper than antipyrin.

I am, Sirs, yours truly,
Woolwich Common, Nov. 7th, 1887. THEODORE MAXWELL.

COMMUNICATION OF RABIES.

To the Editors of THE LANCET.

SIRS,—In your issue of Oct. 22nd I notice that your Paris correspondent refers to "a precursor of Pasteur," and in your issue of the following week Mr. Lambert points out that herbivora can communicate rabies, but does not say to which class of animals. It may be of interest to some of your readers to learn that M. Reynault has caused rabies in sheep by inoculation from rabid sheep, also that Prof. Nocard of Alfort, in a letter to me last summer, stated that he had often given rabies of the horse to the dog, sheep, and rabbit by inoculation of the saliva. Prof. Duguid, of the Privy Council Office, informed me last summer that paralytic rabies was communicated to rabbits by inoculation of the medulla from rabid deer in Richmond-park, and also that true rabies was induced in a dog by a similar inoculation.

I remain, Sirs, your obedient servant,
Edinburgh, Nov. 8th, 1887. W. OWEN WILLIAMS, F.R.C.V.S.

"CHANGE OF AIR."

To the Editors of THE LANCET.

SIRS,—Will any of your readers kindly inform me where is to be found any good account of the reasons why "change of air" is of benefit?

I am, Sirs, faithfully yours,
Southport, Oct. 31st, 1887. EDWARD DAY MCNICOLL.

A Registered Practitioner, but never a Rejected Student.—We are unable to agree with our correspondent in his facts and inferences, whilst his proposals are surely quite impracticable. Examiners differ, no doubt; but there can be no question that in every one of the points referred to the examination system has vastly improved, and that, as a rule (with the fewest possible exceptions), those who pass and those who are rejected deserve their fate. No useful purpose will be served by publishing the letter.

Z.—We propose to publish an article on the question in an early number.

Dr. Myrtle.—Very soon.

COMMUNICATIONS not noticed in our present number will receive attention in our next.

COMMUNICATIONS, LETTERS, &c., have been received from—Prof. Windle, Birmingham; Dr. Dickinson, London; Dr. Bristowe, London; Sir P. Eade, Norwich; Dr. Lindsay Steven, Glasgow; Messrs. J. Dewar and Sons, Perth; Prof. Owen Williams, Edinburgh; Messrs. Colnaghi and Co., London; Messrs. A. and J. Shaw, Grantham; Mr. Reginald Harrison, Liverpool; Dr. W. Fraser, Ashburton; Dr. Jas. Oliver, London; Dr. Groom, Wisbech; Mr. Lockwood, London; Mr. Biggs, Leicester; Mr. Young, London; Mr. J. Dixon, Kempston; Mr. Frank; Mr. F. Collins, London; Mr. Snell, Sheffield; Messrs. Harrison and Brass, Elgin; Mr. Fitzgerald, Folkestone; Dr. Battiscombe, St. Mary Cray; Mr. Cathcart, Edinburgh; Dr. Delvaille, Bayonne; Mr. Lawson

Tait, Birmingham; Mr. G. H. Voss, Tottenham; Messrs. Longmans and Co., London; Dr. Robertson, Newcastle-on-Tyne; Mr. Clement Lucas, London; Dr. Mears, Newcastle-on-Tyne; Mr. Wallace, Southsea; Mr. Lawrence, York; Mr. Martin, Edinburgh; Dr. Forsbrook, London; Dr. Gillies, Brockley; Dr. Hilliard, Aylesbury; Mr. Lamb, London; Dr. Robinson, Dublin; Major-General Macdonald, Nairn; Mr. Birchall, Liverpool; Mr. Burke, Barnsley; Messrs. Maythorn and Son, Biggleswade; Dr. C. M. Campbell, London; Messrs. Dawson Bros., Montreal; Dr. Yeo, London; Dr. Yarrow, London; Dr. More Madden, Dublin; Dr. Paul Chapman, Hereford; Messrs. Blake and Co., Leeds; Mr. Holman, London; Mr. Page, London; Mr. Nelson Hardy, London; Dr. J. D. Malcolm, London; Messrs. Oppenheimer and Co., London; Mr. Browning, Manchester; Messrs. Mayer and Meltzer, London; Mr. Day, Norwich; Mr. Connor, Cork; Dr. Percy Boulton, London; Dr. Thudichum, London; Mr. Hooker, Bournemouth; Dr. Griffith, London; Mr. J. F. Littler, London; Mr. Godson, Birmingham; Mr. Alcan, Paris; Dr. Hillyer, Balham; Mr. Vickers, London; Mr. Beales, Yarmouth; Mr. Morgan, Stafford; Mr. Heap, Birkenhead; Mr. Aubanel, Paris; Mr. Woolley, Hove; Mr. Brown, Brompton; Mr. Stephenson, Ontario; Mr. Hambleton; Mr. Mercer, London; Mr. Beales, London; Mr. Watson, Lanark; Dr. Bogle, Cape Colony; Dr. Simms, London; Mr. Newbold; Messrs. Tillotson and Son, Bolton; Mr. A. A. C. Swinton, London; Messrs. Reynolds and Co., Leeds; Mr. Cross, Acton; Mr. Hall, Liverpool; Messrs. Slinger and Co., York; Mr. Love, Wolverhampton; Mr. Lestrange; Mr. W. Frost, London; Mr. Meadows, Hastings; Mr. Papillon; Mr. Gostling, Worcester; Mr. Maunsell, Sherborne; Mr. Larksman; Mr. Renshaw, London; Mr. Cole, Brixton; Mr. Johnson, Leicester; Dr. Oswald, Clapham; Mr. Sellers, London; Mr. Davey, Islington; Mr. Oldham, Manchester; A Registered Practitioner, &c.; M.D., C.M.; A Subscriber; Ever Grateful; Vertigo; M.R.C.S.; F.G., Hull; Cito; Justitia; H. M.; H. T. R.; Alpha; A. G., Birmingham; Secretary, London.

LETTERS, *each with enclosure*, are also acknowledged from—Mr. Lambton, Rochdale; Mr. Brown, Westgate-on-Sea; Mr. Williams, Tunbridge Wells; Mr. Jury, Liverpool; Mrs. Senet, London; Messrs. Mackie and Co., Edinburgh; Mr. Williams, Birmingham; Mr. Atkinson, Long Sutton; Mr. Robinson, Stockton; Mr. Lowthian; Messrs. Bennett Bros., Salisbury; Mr. Hamilton, St. Ives; Mr. Webster, Shepherd's Bush; Mrs. Brown, London; Mr. Johnston, Glasgow; Messrs. Wyleys and Co., Coventry; Mr. Harrison, Stafford; Mr. Woodcock, Bradford; Mr. Guest, Melsonby; Messrs. Brown, Glasgow; Messrs. Down and Co., London; Dr. Jones, Tonypandy; Messrs. Wood and Co., New York; Mr. Paine, Worthing; Mr. Carter, London; Messrs. Savory and Moore, London; Mr. Wormald, Manchester; Messrs. Rocke and Co., London; Mr. Lace, Bristol; Mrs. Curry; Mr. Jackman, Stoke Newington; Mr. Jackson, Workington; Mr. Teacher, Edinburgh; Mr. Hunt, Manchester; Mr. Thomas, Pwllheli; Mr. Stenhouse, Glasgow; Miss Burnes, Salisbury; Mr. Lamb, Preston; Mr. Coltman, Leicester; Miss Croft, London; Mr. Oliver, Pendlebury; Mr. Lloyd, London; Mr. Gray, Walsall; Mr. Penny, Clifton; Messrs. Boulton and Paul, Norwich; Mr. Ormond, Newton-le-Willows; Messrs. Brown and Co., London; Mr. Barham, Spitalfields; Messrs. Wright and Co., Bristol; Messrs. Shaw, Grantham; Mr. Burgess, Manchester; Mr. Foote, Cirencester; Mrs. Rowcliffe, Cranleigh; Mr. Jones, Liverpool; Mr. Huggins, Malvern; Dr. Tunmer, Harrogate; Mr. Graham, Devonport; Mr. Dean, London; W. F., Southport; M.D., Kineton; A. W.; L., Coventry; Visitor; T., Bath; Q. R.; L. M., Hull; M.D., Kennington; Edin.; X., Helensburgh; B. M., Lincoln; Secretary, Hartlepool; J. M. C., Birmingham; L. M., Hemel Hempstead; V., Bootle; M. J. S.; Lady Superintendent, Burton-on-Trent; Fides, New Cross; H. L.; X. Y. Z., London.

Hebden Bridge Times, Oldham Standard, Naturalists' Monthly, Liverpool Courier, American Grocer, Moncton, N.B., Daily Transcript, &c., have been received.

Medical Diary for the ensuing Week.

Monday, November 14.

ROYAL LONDON OPHTHALMIC HOSPITAL, MOORFIELDS.—Operations, 10.30 A.M., and each day at the same hour.
ROYAL WESTMINSTER OPHTHALMIC HOSPITAL.—Operations, 1.30 P.M., and each day at the same hour.
CHELSEA HOSPITAL FOR WOMEN.—Operations, 3.30 P.M.; Thursday, 2.30.
ST. MARK'S HOSPITAL.—Operations, 2 P.M.; Tuesday, 2.30 P.M.
HOSPITAL FOR WOMEN, SOHO-SQUARE.—Operations, 2 P.M., and on Thursday at the same hour.
METROPOLITAN FREE HOSPITAL.—Operations, 2 P.M.
ROYAL ORTHOPÆDIC HOSPITAL.—Operations, 2 P.M.
CENTRAL LONDON OPHTHALMIC HOSPITALS.—Operations, 2 P.M., and each day in the week at the same hour.
MEDICAL SOCIETY OF LONDON.—8.30 P.M. Sir Andrew Clark: On Fæcal Anæmia.—Mr. A. Pearce Gould: On Estlander's Operation and Thoracoplasty.

Tuesday, November 15.

GUY'S HOSPITAL.—Operations, 1.30 P.M. and on Friday at the same hour. Ophthalmic Operations on Monday at 1.30 and Thursday at 2 P.M.
ST. THOMAS'S HOSPITAL.—Ophthalmic Operations, 4 P.M.; Friday, 2 P.M.
CANCER HOSPITAL, BROMPTON.—Operations, 2.30 P.M.; Saturday, 2.30 P.M.
WESTMINSTER HOSPITAL.—Operations, 2 P.M.
WEST LONDON HOSPITAL.—Operations, 2.30 P.M.
ST. MARY'S HOSPITAL.—Operations, 1.30 P.M. Consultations, Monday, 2.30 P.M. Skin Department, Monday and Thursday, 9.30 A.M.
PATHOLOGICAL SOCIETY OF LONDON.—8.30 P.M. Report of Morbid Growths Committee on Dr. Jacob's Tumour of Skull. Specimens:—Mr. Spencer: Compound Comminuted Fracture of the Lower Jaw.—Mr. Eve: Central Fibro-sarcoma of Tibia, with Extreme Cystic Degeneration.—Mr. Bland Sutton: Inguinal Hernia in Monkeys.—Dr. Charlewood Turner: Cystic Growth in Supra-renal Capsule and Brain.—Dr. Hale White: Congenital Syphilis producing Lardaceous Disease.—Dr. Dawson Williams: Hydronephrosis.—Mr. Hutchinson, jun.: Adenoma Mammæ, with Supervention of Scirrhus.—Mr. Mansell Moullin: (1) Separation of Upper Epiphysis of Radius; (2) Fracture through Lower Epiphysis of Femur, with Bony Union.

Wednesday, November 16.

NATIONAL ORTHOPÆDIC HOSPITAL.—Operations, 10 A.M.
MIDDLESEX HOSPITAL.—Operations, 1 P.M.
ST. BARTHOLOMEW'S HOSPITAL.—Operations, 1.30 P.M.; Saturday, same hour. Ophthalmic Operations, Tuesday and Thursday, 1.30 P.M. Surgical Consultations, Thursday, 1.30 P.M.
ST. THOMAS'S HOSPITAL.—Operations, 1.30 P.M.; Saturday, same hour.
LONDON HOSPITAL.—Operations, 2 P.M.; Thursday & Saturday, same hour.
GREAT NORTHERN CENTRAL HOSPITAL.—Operations, 2 P.M.
UNIVERSITY COLLEGE HOSPITAL.—Operations, 2 P.M.; Saturday, 2 P.M. Skin Department, 1.45 P.M.; Saturday, 9.15 A.M.
ROYAL FREE HOSPITAL.—Operations, 2 P.M., and on Saturday.
KING'S COLLEGE HOSPITAL.—Operations, 3 to 4 P.M.; Friday, 2 P.M.; Saturday, 1 P.M.
CHILDREN'S HOSPITAL, GREAT ORMOND-STREET.—Operations, 9 A.M.; Saturday, same hour.
OBSTETRICAL SOCIETY OF LONDON.—8 P.M. Drs. Herman, Champneys, and John Williams: Extra-uterine Gestation. No specimens will be shown, except such as illustrate the subject of the meeting.
SOCIETY OF ARTS.—8 P.M. Opening Address by Sir Douglas Galton.

Thursday, November 17.

ST. GEORGE'S HOSPITAL.—Operations, 1 P.M. Ophthalmic Operations, Friday, 1.30 P.M.
CHARING-CROSS HOSPITAL.—Operations, 2 P.M.
NORTH-WEST LONDON HOSPITAL.—Operations, 2.30 P.M.
THE PARKES MUSEUM OF HYGIENE.—5 P.M. The Rt. Hon. The Earl of Meath: The Importance of Open Spaces.
HARVEIAN SOCIETY OF LONDON.—8.30 P.M. Mr. Knowsley Thornton: Oöphorectomy.

Friday, November 18.

ROYAL SOUTH LONDON OPHTHALMIC HOSPITAL.—Operations, 2 P.M.
SOCIETY OF MEDICAL OFFICERS OF HEALTH.—7.30 P.M. Dr. W. N. Thursfield: Pasteur's System of Preventive Treatment of Hydrophobia.

Saturday, November 19.

MIDDLESEX HOSPITAL.—Operations, 2 P.M.

SUBSCRIPTION.

POST FREE TO ANY PART OF THE UNITED KINGDOM.

One Year ..... £1 12 6 | Six Months £0 16 3
To CHINA AND INDIA ..... One Year 1 16 10
To THE CONTINENT, COLONIES, AND UNITED STATES ..... Ditto 1 14 8

Post Office Orders should be addressed to JOHN CROFT, THE LANCET Office, 423, Strand, London, and made payable at the Post Office, Charing-cross.

Notices of Births, Marriages, and Deaths are charged five shillings.

Cheques to be crossed "London and Westminster Bank."

ADVERTISING.

Books and Publications (seven lines and under) ...	£0 5 0
Official and General Announcements	0 5 0
Trade and Miscellaneous Advertisements	0 4 6
Every additional Line	0 0 6
Front Page ... ... per Line	0 1 0
Quarter Page	1 10 0
Half a Page	2 15 0
An entire Page	5 5 0

The Publisher cannot hold himself responsible for the return of testimonials, &c., sent to the office in reply to advertisements; copies only should be forwarded.

NOTICE.—Advertisers are requested to observe that it is contrary to the Postal Regulations to receive at Post-offices letters addressed to initials only.

An original and novel feature of "THE LANCET General Advertiser" is a special Index to Advertisements on page 2, which not only affords a ready means of finding any notice, but is in itself an *additional* advertisement.

Advertisements (to ensure insertion the same week) should be delivered at the Office not later than Wednesday, accompanied by a remittance.

Answers are now received at this Office, by special arrangement, to Advertisements appearing in THE LANCET.

Terms for Serial Insertions may be obtained of the Publisher, to whom all letters relating to Advertisements or Subscriptions should be addressed.

Advertisements are now received at all Messrs. W. H. Smith and Son's Railway Bookstalls throughout the United Kingdom and all other Advertising Agents.

Agent for the Advertising Department in France—J. ASTIER, 66, Rue Caumartin, Paris.